

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 1 0 2 2	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH			MONTH DAY YEAR		2b. HOUR	
LILLIE BEATRICE HABERCAM					JANUARY 9, 1982					7:30 P M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		Cau.		MONTH DAY YEAR 2 11 94		87 YRS		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
England		USA				BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
BALTIMORE			MARYLAND GENERAL HOSPITAL			Housewife					
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			
Md.				---		Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				13e. STREET ADDRESS			
John Bates				Alice Lutchye				2211 West Rodgers Ave.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS					
no				213-05-9893		Wesley Home 2211 West Rodgers Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> 4280 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (b) <u>CONGESTIVE HEART FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from <u>December 31</u> , 19 <u>81</u> , to <u>January 9</u> , 19 <u>82</u> , that <u>xx</u> (we) last saw the deceased alive on <u>January 9</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Katherine Mealy M.D.</i> DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Katherine Mealy, M.D.								22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial				1-12-82		Green Mount Cemetery		Balto Md.			
24. FUNERAL DIRECTOR NAME ADDRESS Burgee Funeral Home 3631 Falls Rd. 21211						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>Thomas Jan Nether</i>			
						JAN 18 1982					

1941 JANUARY 11

Dr. J. H. ...  
BALTIMORE, MD.

HARVARD GENERAL HOSPITAL

Mr. J. H. ...

John ...

no ...

RESPIRATORY FAILURE

CONGESTIVE HEART FAILURE

January 11, 1941

1-12-41

1941 JANUARY 11



Items #10a-22a Film G564 2/3/82 r STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Dolores Anna Haberkam			2a. DATE KNOWN OF DEATH MONTH DAY YEAR 1 15 1982			2b. HOUR M P. M.					
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 2 28 28		6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1 15 1982		7d. HOUR P. M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.		
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital - STU			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Inspector-Crown			12b. KIND OF BUSINESS OR INDUSTRY Cork&Seal		
13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 117 Wise Avenue		
14. FATHER'S NAME FIRST MIDDLE LAST Valentine Behr			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Connie Goeb			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 216-24-3580		
17. INFORMANT 500 Bayside Drive John H. Haberkam Balto., MD. 21222			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot Wounds to Abdomen and Neck 9550 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 1:15 1/15/82			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Self inflicted					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home			21f. LOCATION 117 Wise Ave. Baltimore Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Virginia L. Dolan			TITLE (SPECIFY) M.D. Assistant			DATE SIGNED 1-16-82					
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.			ADDRESS 111 Penn Street								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1/19/1982			23c. NAME OF CEMETERY OR CREMATORY Sacred Ht. Of Jesus					
23d. LOCATION CITY OR TOWN Baltimore			COUNTY Maryland			STATE					
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc.			ADDRESS 7922 Wise Avenue Dundalk, MD. 21222			25a. DATE REC'D. BY REGISTRAR JAN 19 1982					
25b. REGISTRAR SIGNATURE Charles J. Smith											

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE JUDICIAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

SECRET

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 1 0 2 4			
1. FOR STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) <b>JAMES H. HALL</b>				2a. DATE OF DEATH MONTH <b>1</b> DAY <b>16</b> YEAR <b>82</b> 7b HOUR <b>3:20 a.m.</b>			
3 SEX <b>MALE</b>		4 RACE <b>Black</b>		5. DATE OF BIRTH MONTH <b>7</b> DAY <b>31</b> YEAR <b>18</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>63</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>South Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>VAMC BALTIMORE, MARYLAND 21218</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS <b>1301 N. LAKEWOOD AVE.</b>		14 FATHER'S NAME FIRST <b>Simon</b> MIDDLE <b>Hall</b> LAST		15. MOTHER'S MAIDEN NAME FIRST <b>Elease</b> MIDDLE <b>Jacobs</b> LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES AND/OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>248 20 5508</b>		17 INFORMANT <b>Frances Pulliam</b> 1301 N. Lakewood VAMC records, Baltimore, Maryland 21218			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiopulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>septic shock</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>radiation colitis</b> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Biliary Carcinoma</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>DECEMBER 25</b> , 19 <b>81</b> , to <b>JANUARY 16</b> , 19 <b>82</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>JANUARY 16</b> , 19 <b>82</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> view the body after death.							
22b. SIGNATURE <b>J. Posner, MD</b> DEGREE <b>MD</b>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1/16/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>J. Posner, MD</b>				22e. ADDRESS <b>Balt VAMC</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/22/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cem.</b>		23d. LOCATION CITY OR TOWN <b>Baltimore</b> COUNTY <b>MD</b> STATE	
24 FUNERAL DIRECTOR NAME <b>Wm. C. March F/H</b> ADDRESS <b>1101 E. North Ave.</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 18 1982</b> REGISTRAR'S SIGNATURE <b>[Signature]</b>			

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified for necropsy.

FOR dad 1- STATE REGISTRAR				DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 1 0 2 5 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>KATHRYN S HALL</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>JAN 2 1982</b>				2b. HOUR <b>3:11 A.M.</b>			
3. SEX <b>FEMALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>DEC 8 1914</b>		6. AGE (IN YEARS (LAST BIRTHDAY)) <b>67</b> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Chase, Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto.</b> MD.					
10. CITY OR TOWN OF DEATH <b>Balto</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Good Samaritan Hosp</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Md.</b>		13b. COUNTY		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2501 Violet Ave.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Louis Beasley</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ella Mae</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO.		17. INFORMANT <b>James Hall</b>				ADDRESS <b>2501 Violet Ave.</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO-RESPIRATORY ARREST</b> <b>4360</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>MASSIVE BILATERAL CVA</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>CHRONIC HYPERTENSION</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Previous MI - 1977-1978</b>											
19a. DATE OF OPERATION <b>12-28-81</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>FOR FEEDING GASTROSTOMY</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 30</b> , 19 <b>81</b> , to <b>JAN 2</b> , 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>JAN 1</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Ricla Rosa</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>JAN 2 1982</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ROMULO DELA ROSA</b>				22e. ADDRESS <b>GOOD SAMARITAN HOSPITAL</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/8/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sharp St. Meth.</b>				23d. LOCATION CITY OR TOWN STATE <b>Chase, Md.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Leroy D. Dyett FH 4600 Lib. Hgts.</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 4 1982</b>		25b. REGISTRAR'S SIGNATURE <b>Ricla Rosa</b>					





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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>JOHN WARREN HAMLETT</b>		2a. DATE OF DEATH MONTH <b>1</b> DAY <b>11</b> YEAR <b>82</b>		2b. HOUR <b>4:55AM</b> M
3. SEX <b>MALE</b>	4. RACE <b>BLACK</b>	5. DATE OF BIRTH MONTH <b>9</b> DAY <b>22</b> YEAR <b>22</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>60</b>
7a. BIRTHPLACE (STATE OR FOREIGN) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE, CITY</b> MD		
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>VAMC, 3900 LOCH RAVEN BLVD.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>LABORER</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>	13c. CITY OR TOWN <b>BALTIMORE</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST <b>Edward</b> MIDDLE <b>Hamlett</b> LAST <b>Hamlett</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Mathe</b> LAST <b>Simpson</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <b>YES</b> OR UNKNOWN <input type="checkbox"/> (IF WWII WAR OR DATES)		16b. SOCIAL SECURITY NO. <b>214 12 1276</b>		17. INFORMANT NAME <b>Clara Collins Hamlett</b> ADDRESS <b>16 25th N. Milton</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Left Ventricular and Right atrial mural thrombi</b> <b>4254</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>cardiomyopathy</b> DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>no</b>				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>1-3</b> , 19 <b>82</b> , to <b>1-11</b> , 19 <b>82</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>1-11</b> , 19 <b>82</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> view the body after death.				
22b. SIGNATURE <b>David L. Wilson M.D.</b>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1/11/82</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DAVID L. WILSON, M.D.</b>		22e. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>1/16/82</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Smt. Calvary</b>		23d. LOCATION CITY OR TOWN <b>A. A. County, Md</b> COUNTY STATE
24. FUNERAL DIRECTOR NAME <b>LOCK'S FUNERAL HOME</b> ADDRESS <b>1304 N. Central St</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 13 1982</b>		25b. REGISTRAR'S SIGNATURE <b>Shane J. [Signature]</b>

72 2 135

THE UNIVERSITY OF CHICAGO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 7/77  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>NORMAN C</b>		MIDDLE <b>HAMLIN</b>		LAST <b>HAMLIN</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>01 13 82</b>		2b. HOUR <b>1:40 A</b>	
3. SEX <b>M</b>		4. RACE <b>B.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1-25-1916</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VIR.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO, CITY</b> MD.			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PROVIDENT HOSP</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>LABORER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>RIGGER</b>	
13a. STATE <b>Md.</b>		13b. COUNTY <b>BALTO</b>		13c. CITY OR TOWN <b>BALTO</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>5012 Dickey Hill Rd.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOHN A. Hamlin</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>IDA Edwards</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. <b>214-16-3776</b>		17. INFORMANT ADDRESS <b>ERNESTINE HAMLIN 1642 ST PRESTON</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b> <b>4939</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>BRONCHIAL ASTHMA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>12-16</b> , 19 <b>81</b> , to <b>1-13</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>1-13</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Isaiah W. Dimery MD</b>		DEGREE <b>MD</b>				22c. DATE SIGNED <b>1-13-82</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ISAIAH W. DIMERY</b>	
22e. ADDRESS <b>2600 LIBERTY HTS</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <b>1-18-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ARbutus Mem</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MD</b>		23e. DATE REC'D. BY REGISTRAR <b>JAN 18 1982</b>	
24. FUNERAL DIRECTOR NAME <b>BROWN THOMPSON F. H.</b>		ADDRESS <b>1913 W. BALTO ST</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 18 1982</b>		25b. REGISTRAR'S SIGNATURE <b>James J. Martin</b>			

MEDICAL CERTIFICATION

(11)

THE UNIVERSITY OF CHICAGO  
LIBRARY  
1215 EAST 58TH STREET  
CHICAGO, ILL. 60637  
TEL. 733-4331  
FAX 733-4331  
WWW.CHICAGO.EDU

THE UNIVERSITY OF CHICAGO  
LIBRARY  
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TEL. 733-4331  
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WWW.CHICAGO.EDU

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 0 1 0 2 8			
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
WILLIAM F. HAMMER SR.				JANUARY 4 1982			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
MALE		WHITE		MONTH 08 DAY 25 YEAR 06		75 YRS	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
MARYLAND		U.S.A.				CITY MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE		ST. AGNES HOSPITAL, CHOPIN, BALT		MEAT CUTTER		MARKET	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS?			
13a. STATE MARYLAND 13b. COUNTY --- 13c. CITY OR TOWN BALTIMORE				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
George William Hammer				Lena B. McMullen			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
YES		WW II		RHIDA B. HAMMER 2655 ST. BENEDICT ST. 21223			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) 4960 CHRONIC obstructive pulmonary disease							5 yrs
DUE TO, OR AS A CONSEQUENCE OF (b)							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
cor pulmonale, fractured nose, angina pectoris							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
		HOUR (A.M.) MONTH DAY YEAR		Pt fell and broke his nose			
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		[AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]		CITY OR TOWN COUNTY STATE			
		HOMES		2655 ST BENEDICT ST BALTIMORE MD 21223			
22a. I certify that (1) (this hospital) attended the deceased from September 19 80, to January 4 19 81, that (1) (we) lost the deceased alive on JANUARY 3 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
Charles R. Graham Jr.				MD		1/4/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
CHARLES R. GRAHAM JR				6207 Frederick Rd Belts Md 21228			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
BURIAL		01-06-82		LOUDON PARK		BALTIMORE CITY MARYLAND	
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR			
NAME ADDRESS HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. 21229				JAN 6 1982			
25b. REGISTRAR'S SIGNATURE				25c. REGISTRAR'S SIGNATURE			
				James J. Nathan			





added info g564 2/18/82 gj

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Charles Handy</b>				2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR <b>1 25 19 82</b>				2b. HOUR <b>M</b>			
3. SEX <b>male</b>	4. RACE <b>black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>2-24-35</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>46 YRS.</b>	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>1 25 1982</b>	7d. HOUR <b>7:57A</b>					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Agnes Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>MD</b>		13b. COUNTY <b>Lithium</b>		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>443 W. Maple Rd</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Arthur Armstrong</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ella Radenux</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT <b>Rufus Handy</b>		17. ADDRESS <b>1293 Stanton Rd</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>Cardio-respiratory arrest</b> IMMEDIATE CAUSE (a) <b>8763 complications of placement of endotracheal tube</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: <b>(b) during anesthesia induction</b> DUE TO, OR AS A CONSEQUENCE OF <b>(c)</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 1/12/ 19 82</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Therapeutic misadventure</b>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>hospital</b>				21f. LOCATION CITY OR TOWN <b>St. Agnes Hospital, Baltimore, Maryland</b> COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <b>Virginia L. Dolan</b>				TITLE (SPECIFY) M.D. <b>Assistant</b> MEDICAL EXAMINER				DATE SIGNED <b>1/25/82</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Virginia L. Dolan, M.D.</b>				ADDRESS <b>111 Penn Street, Baltimore, MD 21201</b>							
23a. BURIAL, CREMATION, REMOVAL SPECIFY <b>Burial</b>				23b. DATE <b>1/30/82</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Church Cem</b>			
23d. LOCATION CITY OR TOWN <b>CARONCRO</b> COUNTY <b>Ther</b> STATE				24. FUNERAL DIRECTOR NAME <b>VERNON R. Bailey</b> ADDRESS <b>1348 N. Calhoun</b>				25a. DATE REC'D. BY REGISTRAR <b>FEB 5 1982</b> 25b. REGISTRAR'S SIGNATURE <b>Charles J. [Signature]</b>			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M 2/80

EXHIBITION

FIBER

EXHIBITION

EDMUND

Edmund

1908

Feb 2

1908

1908

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 1 0 3 0			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>OWEN LOUIS HARDESTY</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>JANUARY, 2, 1982</b>		2b. HOUR <b>8<sup>45</sup> P M</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8 - 25 - 98</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>83</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> UNMARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>LUTHERAN Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>TOBACCO FARMER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>TENANT</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>PR. GEO'S</b>		13c. CITY OR TOWN <b>RIVERDALE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>UNKNOWN</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>UNKNOWN</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES <b>NO --</b>			
16b. SOCIAL SECURITY NO. <b>213-56-9109</b>		17. INFORMANT ADDRESS <b>RUSSELL D. HARDESTY-RIVERDALE, MD. 20737</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio Respiratory Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Sepsis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Dehydration</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>2765</b>							
19a. DATE OF OPERATION							
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>12/31/81</b> , 19 <b>82</b> , to <b>1/2</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>1/2</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE OF PHYSICIAN <b>Muger Gebremariam</b>				22c. DATE SIGNED <b>1/2/82</b>		22d. ADDRESS <b>Lutheran Hospital Baltimore, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>		23b. DATE <b>1/6/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>WASHINGTON NAT'L CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>SUITLAND (Pr. Geo's) Md.</b>	
24. FUNERAL DIRECTOR <b>Richard A. Coleman - Upper Marlboro, Maryland 20772</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 7 1982</b>			
25b. REGISTRAR'S SIGNATURE <b>James J. [Signature]</b>							

0343

Handwritten: 1-0710

542, 2, 11, 12, 13,

514 M

2019/81

7-28-8

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1003

Y. S. Smith

1970-1971

[illegible]

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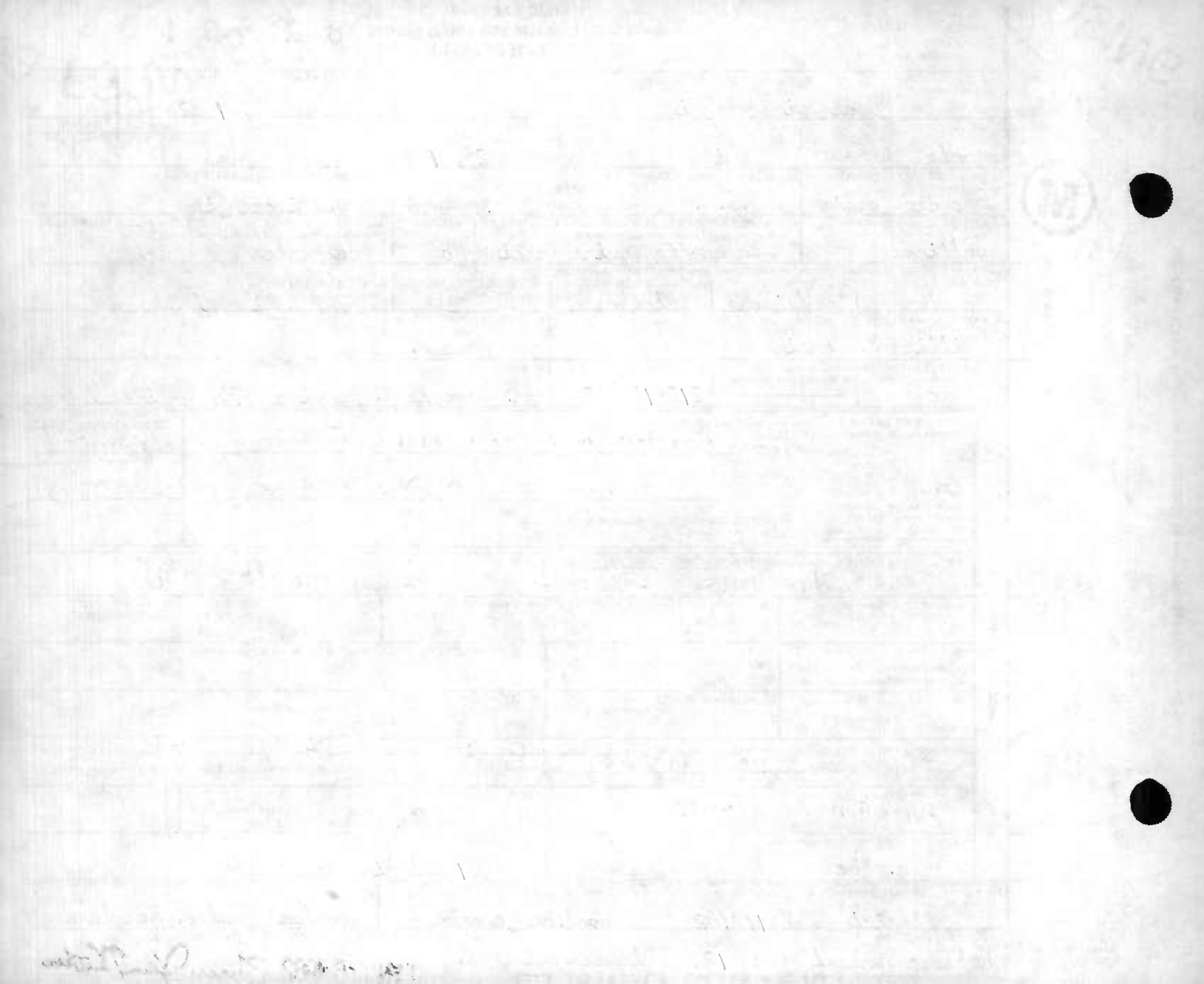
NOTE: P-0-534

73

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 1 0 3 1	
1- FOR STATE REGISTRAR		REG. NO.									
1 DECEASED NAME (TYPE OR PRINT) <i>Edgar Owings Harding</i>					2a DATE OF DEATH <i>January 4, 1982</i>			2b HOUR <i>M</i>			
3 SEX <i>male</i>		4 RACE <i>white</i>		5 DATE OF BIRTH MONTH DAY YEAR <i>October 26, 1986</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>95</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Howard County</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.					
10 CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Lafayette Squire Nursing Home</i>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>carpenter</i>		12b KIND OF BUSINESS OR INDUSTRY <i>self</i>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a STATE <i>Maryland</i>		13b COUNTY <i>Baltimore</i>		13c CITY OR TOWN <i>Halethorpe</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <i>5747 A Mineral Avenue</i>			
14 FATHER'S NAME FIRST MIDDLE LAST <i>William H. Harding</i>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Emma V. Jones</i>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>				16b SOCIAL SECURITY NO <i>212-12-4628</i>		17 INFORMANT ADDRESS <i>Mr. Theodore A. Harding 5747 A-Mineral Avenue</i>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Cardio-pulmonary arrest</i> <i>3109</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chronic brain syndrome</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>terminal</i> <i>several yr.</i>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Fracture (L) Hip. - 4 months ago.</i>											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (I) (this hospital) attended the deceased from <i>12/16/81</i> to <i>12/17</i> 19 <i>81</i> , that (I) (we) lost saw the deceased alive on <i>Dec. 21</i> 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <i>Amir N. Naeem</i>				DEGREE <i>MD</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c DATE SIGNED			
22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>Dr. Naeem</i>				22e ADDRESS <i>501 Dolphin Street</i>							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>burial</i>		23b DATE <i>1/7/82</i>		23c NAME OF CEMETERY OR CREMATORY <i>Woodlawn Cemetery</i>		23d LOCATION CITY OR TOWN COUNTY STATE <i>Woodlawn Balto. Maryland</i>					
24 FUNERAL DIRECTOR NAME ADDRESS <i>Ambrose Funeral Home 1328 Sulphur Spring Rd.</i>				25a DATE REC'D. BY REGISTRAR <i>JAN 6 1982</i>		25b REGISTRAR'S SIGNATURE <i>James Van Nuthen</i>					





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2b. DATE KNOWN OF DEATH			XX MONTH DAY YEAR			2d. HOUR			
Eulla McKesson			Harding			1-14-82			12:38			M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD			
female		black		Feb 9/18		63 YRS.		MONTHS		DAYS		1-14-82			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH			
North Carolina				USA								Baltimore City			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore				318 N. Stricker Street				Maed - Ret.							
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
13a. STATE 13b. COUNTY												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		318 N. Stricker St	
14. FATHER'S NAME												15. MOTHER'S MAIDEN NAME			
General												Blossie O. Richardson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)												16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
												233-24-7711		Jas. H. McKesson - 3641 Dolefield	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease															
4292															
DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.															
(b)															
DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?			
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
				HOUR A.M. MONTH DAY YEAR											
				P.M. 19											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION				CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE				TITLE (SPECIFY)								DATE, SIGN			
Margarita A. Korell, M.D.				Assistant MEDICAL EXAMINER								1-15-82			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS								111 Penn Street			
23a. BURIAL, CREMATION, REMOVAL				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION			
Burial				1/19/82				Arbutus Men. Park				Arbutus			
												COUNTY STATE			
												Md.			
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
Chas. H. Powell F/H				JAN 18 1982				[Signature]							
NAME ADDRESS															
319 N. Schroeder St															

Gen. H. G. W. H. - 31.12.1914 - 31.12.1914

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 1 0 3 3	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) George Allen Hare					2a. DATE OF DEATH MONTH DAY YEAR 1-18-82			2b. HOUR 3:15 AM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3 13 20		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> XX		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) John L. Deaton Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrical		12b. KIND OF BUSINESS OR INDUSTRY Contract			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE MD		13b. COUNTY -		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2117 Sulgrave Avenue			
14. FATHER'S NAME FIRST MIDDLE LAST Omer R. Hare					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie B. Yerger						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17. INFORMANT ADDRESS Michael B. Hare 1601 Ywin Maple Avenue							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 4360 DUE TO, OR AS A CONSEQUENCE OF (b) <u>COA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 1 1/2 hr											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that the (name) (hospital) attended the deceased from saw the deceased alive on 1/18/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (a) (we) (did) (did not) view the body after death.											
22b. SIGNATURE J. Raymond Gladu, M.D.					DEGREE ATTENDING PHYSICIAN			22c. DATE SIGNED 1/18/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/21/82		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Pikesville, Baltimore Co., Md					
24. FUNERAL DIRECTOR Burgee Funeral Home 3631 Falls Road 21211					25a. DATE RECEIVED BY REGISTRAR JAN 20 1982						

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(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 1 0 3 4 REG. NO.			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
FIRST MIDDLE LAST <b>CLIFTON HARGROVE</b>				MONTH DAY YEAR <b>JANUARY 22, 1982</b>			
3. SEX <b>Male</b>				7b. HOUR <b>1:30AM</b>			
4. RACE <b>Black</b>				5. DATE OF BIRTH			
				MONTH DAY YEAR <b>5 17 26</b>			
6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR			
<b>55</b>				MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>JOHNS HOPKINS HOSPITAL</b>			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>MD</b>				13b. COUNTY			
13c. CITY OR TOWN <b>Baltimore</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13e. STREET ADDRESS <b>2040 E. Biddle Street</b>							
14. FATHER'S NAME FIRST MIDDLE LAST <b>Burley Hargrove</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Thelma Watts</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>				16b. SOCIAL SECURITY NO. <b>220-18-4801</b>			
17. INFORMANT <b>Clifton Hargrove, Jr.</b>				ADDRESS <b>1633 Freedomway N.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>RESPIRATORY FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>PNEUMONIA</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>SECONDS</b> <b>2 DAYS</b> <b>3 DAYS</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>SEIZURE DISORDER</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN IDENTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>1/11</b> , 19 <b>82</b> , to <b>1/22</b> , 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>1/22</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>David B Pearse</b> MD				DEGREE <b>MD</b>		22c. DATE SIGNED <b>1/22/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DAVID PEARSE</b> MD				22e. ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/27/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Crownsville Va Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Crownsville MD</b>	
24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H, Inc.</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 25 1982</b>			
ADDRESS <b>1101 E. North Ave.</b>				25b. REGISTRAR'S SIGNATURE <i>James J. [Signature]</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <b>Frances B. Harig</b>					2a. DATE OF DEATH MONTH <b>1</b> DAY <b>2</b> YEAR <b>1982</b>				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>4</b> DAY <b>1</b> YEAR <b>1917</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b> YRS.		2b. HOUR <b>M</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>5100 N. Charles St.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret Tax consultant</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>R.R.</b>	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>5100 N. Charles St.</b>	
14. FATHER'S NAME FIRST <b>Frank W.</b> MIDDLE <b>Barringer</b> LAST <b></b>					15. MOTHER'S MAIDEN NAME FIRST <b>Florence</b> MIDDLE <b></b> LAST <b>Clarke</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>216 12 6876</b>		17. INFORMANT ADDRESS <b>Harold C. Barringer 6017 Williams Rd.</b>					
18. CAUSE OF DEATH - Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Mesothelioma</b> <b>1991</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b></b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a <b>Cerebrovascular Accident</b>									
19a. DATE OF OPERATION <b>—</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>Feb 8</b> , 19 <b>80</b> , to <b>Jan 2</b> , 19 <b>82</b> that (I) (we) lost saw the deceased alive on <b>Jan 2</b> , 19 <b>82</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Davis M. Hahn</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>1/4/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Davis M. Hahn</b>				22e. ADDRESS <b>5801 Loch Raven Blvd 21237</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/5/1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Woodlawn Balto Md</b>			
24. FUNERAL DIRECTOR NAME <b>Mitchell-Wiedefeld Home</b>				ADDRESS <b>6500 York Rd.</b>		25a. PREPARED BY REGISTRAR <b>JAN 7 1982</b>		25b. REGISTERED BY REGISTRAR <b>[Signature]</b>	

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OFFICE OF THE  
ATTORNEY GENERAL

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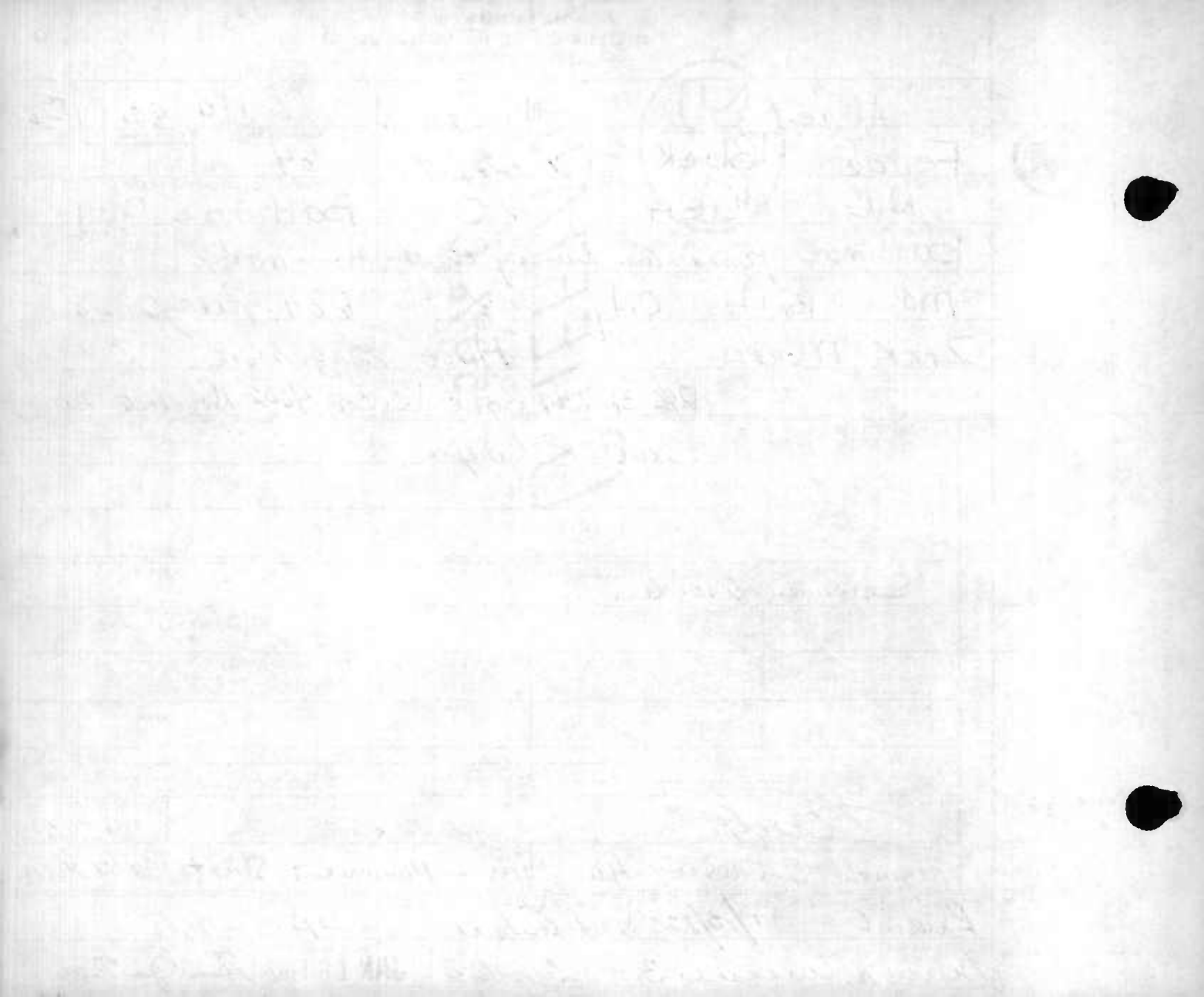
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Alice Harrell</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>1/9/82</i>					2b. HOUR <i>1:58 PM</i>	
3. SEX <i>Female</i>		4. RACE <i>Black</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>1/22/17</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>64</i> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS <i>1</i> MONTHS <i>9</i> DAYS		7. IF UNDER 24 HRS HOURS MIN. <i>58</i> HRS <i>58</i> MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>N.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.					
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Penna. Ave. Nursing Ctr. etc.</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Md</i> 13b. COUNTY <i>Balto</i> 13c. CITY OR TOWN <i>City</i>						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>607 Pennsylvania Ave.</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>ZACK Morris</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Alice Bazemore</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. <i>246-38-1367</i>		17. INFORMANT NAME <i>Rotie Wilcox</i>		17. ADDRESS <i>4002 Norchester Rd.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cancer of Larynx</i> 1619 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <i>Seizure disorders</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>R. O. Crosley</i>				DEGREE				22c. DATE SIGNED <i>1/9/82</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Reginald O. CROSLY MD</i>				22e. ADDRESS <i>1235 E. Monument Street Balto Md 21202</i>							
23a. BURIAL, CREMATION, REMOVAL (TYPE) <i>Burial</i>		23b. DATE <i>1/13/82</i>		23c. NAME OF CEMETERY OR CREMATORY <i>mt. Auburn</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>HAC Md.</i>					
24. FUNERAL DIRECTOR NAME <i>Danny M. Wallace</i>				24. ADDRESS <i>3405 W. Franklin St</i>		25a. DATE REC'D. BY REGISTRAR <i>JAN 18 1982</i>		25b. REGISTRAR'S SIGNATURE <i>Thomas J. North</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director. Pages 3 and 4 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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FOR  
1- STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>SUSIE</b>		MIDDLE <b>HARRELL</b>		LAST <b>HARRELL</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>JAN. 25, 1982</b>		2b. HOUR <b>11 A.M.</b>	
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11/10/1901</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balt. near Colby</b>		MD.	
10. CITY OR TOWN OF DEATH <b>Balt. City</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3701 Manchester St</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>retired</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>MD</b>		13b. COUNTY		13c. CITY OR TOWN <b>Balt. City</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3701 Manchester St</b>	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Carrie Stokes</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Mrs. John H. H-3701 Manchester St.</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sudden DEATH (Cardiopulmonary arrest)</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>MYOCARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ASCVD (st. post Sudden death DEC 1981)</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>immediately</b> <b>MINUTES</b> <b>YEARS</b>
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **—**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>1/20/82</b> to <b>1/25/82</b> , that (I) (we) last saw the deceased alive on <b>1/20/82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.							
22b. SIGNATURE <b>[Signature]</b>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1/20/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>C. HALMA</b>		22e. ADDRESS <b>ST. AGNES HOSPITAL</b>					
23a. BURIAL, CREMATION, REMOVAL (METHOD)		23b. DATE <b>2/1/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Airy</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balt. City MD</b>	
24. FUNERAL DIRECTOR (NAME) <b>Chun Ch...</b>		ADDRESS <b>712 W. North</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 4 1982</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

JAN. 25, 1903

HARRELL

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 0 1 0 3 8			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <u>LAST MIDDLE FIRST</u> <u>HARRINGTON DOROTHY M.</u>				2. DATE OF DEATH MONTH DAY YEAR <u>1/21/82</u> <u>4:30 AM</u>			
3. SEX <u>F</u>		4. RACE <u>W</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>8/6/20</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>61</u> YRS. # UNDER 1 YEAR: MONTHS <u>0</u> DAYS <u>0</u> HOURS <u>0</u> MIN <u>0</u>	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>MD.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>BALTO. CITY</u> MD.	
10. CITY OR TOWN OF DEATH <u>BALTO.</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>BALTO. CITY HOSP.</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>WAITRESS</u>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>MD.</u> 13b. COUNTY <u>BALTO</u> 13c. CITY OR TOWN <u>ESSEX</u>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <u>319 MARGARET AVE</u>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>CHARLES GLASS</u>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>FLORENCE EVELY</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>		16b. SOCIAL SECURITY NO. <u>219121303</u>		17. INFORMANT ADDRESS <u>GLENDA WEBB ABOVE</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>4148</u> IMMEDIATE CAUSE (a) <u>Cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>myocardial ischemia</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>Diabetes</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <u>L</u>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Bruce Kinosh</u> DEGREE _____				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Bruce Kinosh</u>				22e. ADDRESS <u>BCH</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		23b. DATE <u>1/25/82</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MOUNTAIN VIEW</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>UNION BRIDGE MD.</u>	
24. FUNERAL DIRECTOR NAME <u>J.G. CONNELLY</u> ADDRESS <u>300 MACE</u>				25a. DATE REC'D. BY REGISTRAR <u>JAN 21 1982</u> 25b. REGISTRAR'S SIGNATURE <u>Frances Jean Nathan</u>			



1944  
JULY 21  
1944

(15)

Walter C. Parent 2001 1.8.4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 2 0 1 0 3 9

1. DECEASED NAME (TYPE OR PRINT) Robert Roscoe Harrington			2a. DATE OF DEATH MONTH DAY YEAR 01-28-82		2b. HOUR M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 6 14 1917		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore City Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Painter		12b. KIND OF BUSINESS OR INDUSTRY Wallcrafters			
13a. STATE Maryland			13b. COUNTY Baltimore	13c. CITY OR TOWN Dundalk	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Roscoe Harrington			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Erma Williams		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 155-01-0292		17. INFORMANT 16 Lombardy Drive - Balto. MD. 21222	
18. CAUSE OF DEATH (Enter only one cause on line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable Pulmonary Embolism 4/51 } DUE TO, OR AS A CONSEQUENCE OF (b) 134 } (c) } DUE TO, OR AS A CONSEQUENCE OF PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Ischemic Heart Disease Old Myocardial Infarct					
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED None		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) None	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, SCHOOL, FARM, ETC.) None		21f. LOCATION STREET CITY OR TOWN COUNTY STATE None	
22a. I certify that (I) (this hospital) attended the deceased from 1/27/82 to 1/28/82, and that (I) (my) (our) opinion of death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Dr. Ahmed Nour		22c. ADDRESS None		22d. DATE SIGNED 1/28/82	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/30/1982		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn	
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. 7922 Wise Avenue Dundalk, MD. 21222		25a. DATE REC'D. BY REGISTRAR JAN 29 1982		25b. REGISTRAR'S SIGNATURE [Signature]	

5-10-19

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play the piano 1/2 hour

write 1/2 hour

5/10/19

Jan 28 1980



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FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CLINTON HARRIS Sr.			2a. DATE OF DEATH MONTH DAY YEAR 1 26 82		2b. HOUR 5.36 AM	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 4 23 16		
6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.		7b. CITIZEN OF WHAT COUNTRY? USA		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
12b. KIND OF BUSINESS OR INDUSTRY		13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13b. STREET ADDRESS 331 E. North Ave.		
14. FATHER'S NAME FIRST MIDDLE LAST Robert Harris		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Corintha				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 242-24-5690		17. INFORMANT ADDRESS Willie Ree Harris 331 E. North Ave.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1850 IMMEDIATE CAUSE (a) Acute renal failure DUE TO, OR AS A CONSEQUENCE OF: (b) Metastatic Ca of prostate DUE TO, OR AS A CONSEQUENCE OF: (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 11/15/82 to 1/26/82, that (I) (we) last saw the deceased alive on 1/26/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE [Signature]		DEGREE		22c. DATE SIGNED 1-26-82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Evangelos LIGNOS		22e. ADDRESS 201 E. University Pkwy, 21218				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/30/82		23c. NAME OF CEMETERY OR CREMATORY King Mem. Pk.		
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co. MD		24. FUNERAL DIRECTOR NAME Wm. C. March D/H 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR JAN 27 1982		
25b. REGISTRAR'S SIGNATURE [Signature]						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8201041			
1. FOR STATE REGISTRAR				1. DECEASED NAME (TYPE OR PRINT) <b>ELEANOR MARIA HARRIS</b>			
2a. DATE OF DEATH MONTH DAY YEAR <b>JAN. 3, 1982</b>				2b. HOUR <b>6:50 PM</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 6, 1886</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>95</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>North Charles General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Oil Supply Co.</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John F. Harris</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Maria Regina Harris</b>		13e. STREET ADDRESS <b>2525 W. Belvedere Avenue</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>217 38 2133</b>		17. INFORMANT ADDRESS <b>Clarence J. Harris, Jr., Balto., Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ASCVD</b> <b>4292</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>RENAL INSUFFICIENCY TREATED SEPSIS</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>DEC. 19, 1981</b> , to <b>JAN. 3, 1982</b> , that (I) (we) last saw the deceased alive on <b>JAN. 3, 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>C. Vergara - Soares</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1-3-82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>C. VERGARA - SOARES</b>				22e. ADDRESS <b>N. CHARLES GEN. HOSP. BALT. MD. 21218</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/12/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto., Md.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Henry W. Jenkins &amp; Sons Co. 4905 York Road Balto., Md. 21212</b>				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>JAN 11 1982</b> <b>Charles J. Nathan</b>			

No. 17-25-1127  
 John E. Hart  
 Editor  
 1025 W. Belmont St.  
 Chicago, Ill.  
 U.S. District Court  
 Southern District of New York  
 New York, N.Y.



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 NEW YORK  
 NEW YORK, N.Y.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 1 0 4 2	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) <i>John K. Harris</i>						2a. DATE OF DEATH MONTH DAY YEAR <i>1/31/82</i>		2b. HOUR <i>4:15 PM</i>			
3. SEX <i>Male</i>		4. RACE <i>Black</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>4 14 24</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>57</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>M.D.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>BALTO. CITY</i> MD					
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN FACILITY, GIVE STREET ADDRESS) <i>LUTHERAN HOSP</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <i>M.D.</i>		13b. COUNTY		13c. CITY OR TOWN <i>BALTO</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>1000 APPLETON ST.</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Charles Harris</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Maggie Johnson</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Yes</i>				16b. SOCIAL SECURITY NO. <i>218-14-8359</i>		17. INFORMANT ADDRESS <i>Lorraine Ruth Dorsey 1000 Appleton St.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>CVA</i> <i>4360</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <i>Chronic Alcoholism</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I (this hospital) attended the deceased from <i>12-27</i> , 19 <i>81</i> , to <i>1/31/82</i> , 19 <i>82</i> , that I (we) last saw the deceased alive on <i>1/31/82</i> , 19 <i>82</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (we) (did/did not) view the body after death.											
22b. SIGNATURE <i>S. S. S. Archer MD</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <i>1/31/82</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>S. S. S. Archer</i>				22e. ADDRESS <i>Lutheran Hospital</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>2/5/82</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Md. Veteran Cem.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Crownsville MD</i>					
24. FUNERAL DIRECTOR NAME <i>Wm. C. March F/H</i>				ADDRESS <i>1101 E. North Ave.</i>		25a. DATE REC'D. BY REGISTRAR <i>FEB 3 1982</i>		25b. REGISTRAR'S SIGNATURE <i>James J. North</i>			



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 0 1 0 4 3  
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Rebecca J. Harris		2a. DATE OF DEATH MONTH DAY YEAR 1 13 82 2b. HOUR M	
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 7 22 1879	
6. AGE (IN YEARS LAST BIRTHDAY) 102 yrs YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		10. CITY OR TOWN OF DEATH BALTIMORE	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4305 GARRISON BLVD 21215		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	
12b. KIND OF BUSINESS OR INDUSTRY Home		13a. STATE MD	
13b. COUNTY		13c. CITY OR TOWN BALTIMORE	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4305 GARRISON BLVD 21215	
14. FATHER'S NAME FIRST MIDDLE LAST William Contee		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mathilda Gray	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 220-82-7427	
17. INFORMANT Mr. Thomas B. Contee		ADDRESS Md. 20613	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MI 4100 DUE TO, OR AS A CONSEQUENCE OF (b) HASCVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12/20, 19 81, to 1/13, 19 82, that I (we) lost saw the deceased alive on 1-12, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) not view the body after death.			
22b. SIGNATURE MD DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1-14-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Letson		22e. ADDRESS 3640 Forbes Lane 21215	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment		23b. DATE 1/18/82	
23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Park Baltimore		23d. LOCATION CITY OR TOWN	
24. FUNERAL DIRECTOR NAME BACTU. MD. HENRY K. NUTTER Funeral Home 3035 W. NORTH AVE		25a. DATE REC'D. BY REGISTRAR JAN 18 1982	

20% COTTON



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 2 01044	
1. FOR STATE REGISTRAR						20. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1 13 1982 20. HOUR A. M.					
1. DECEASED NAME (TYPE OR PRINT) Eugene D. Harrison						21. DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> MONTH DAY YEAR 1 13 1982 21. HOUR A. M.					
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 1-2-38		6. AGE (IN YEARS LAST BIRTHDAY) 44 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		22. DATE PRONOUNCED DEAD 1 13 1982 22. HOUR A. M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital-STU				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Insurance Agent		12b. KIND OF BUSINESS OR INDUSTRY Self Emp.			
13a. STATE MD.		13b. COUNTY A.A.		13c. CITY OR TOWN Severna Park		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 410 Holly Farms Rd.			
14. FATHER'S NAME FIRST MIDDLE LAST Thomas E. Harrison						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Krueger					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 712-34-2348		17. INFORMANT ADDRESS E. Ann Harrison Sec. 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound to Head (handgun) 9550 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? (head only) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR <del>XXX</del> MONTH DAY YEAR 4:46 P.M. 1 12 1982				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject shot himself			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 406 Elmwood Ct., Arnold, Anne Arundel Co., Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Virginia L. Dolan				TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 1-13-82			
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.				ADDRESS 111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 1-14-82		23c. NAME OF CEMETERY OR CREMATORY Westview Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Westview Balto. MD.					
24. FUNERAL DIRECTOR NAME Robert S. Barranco				ADDRESS 501 Ritchie Hwy Severna Park MD				25a. DATE REC'D. BY REGISTRAR JAN 10 1982			
								25b. REGISTRAR'S SIGNATURE Anne G. Galloway			

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*[Faint, illegible handwritten text, possibly bleed-through from the reverse side of the page]*

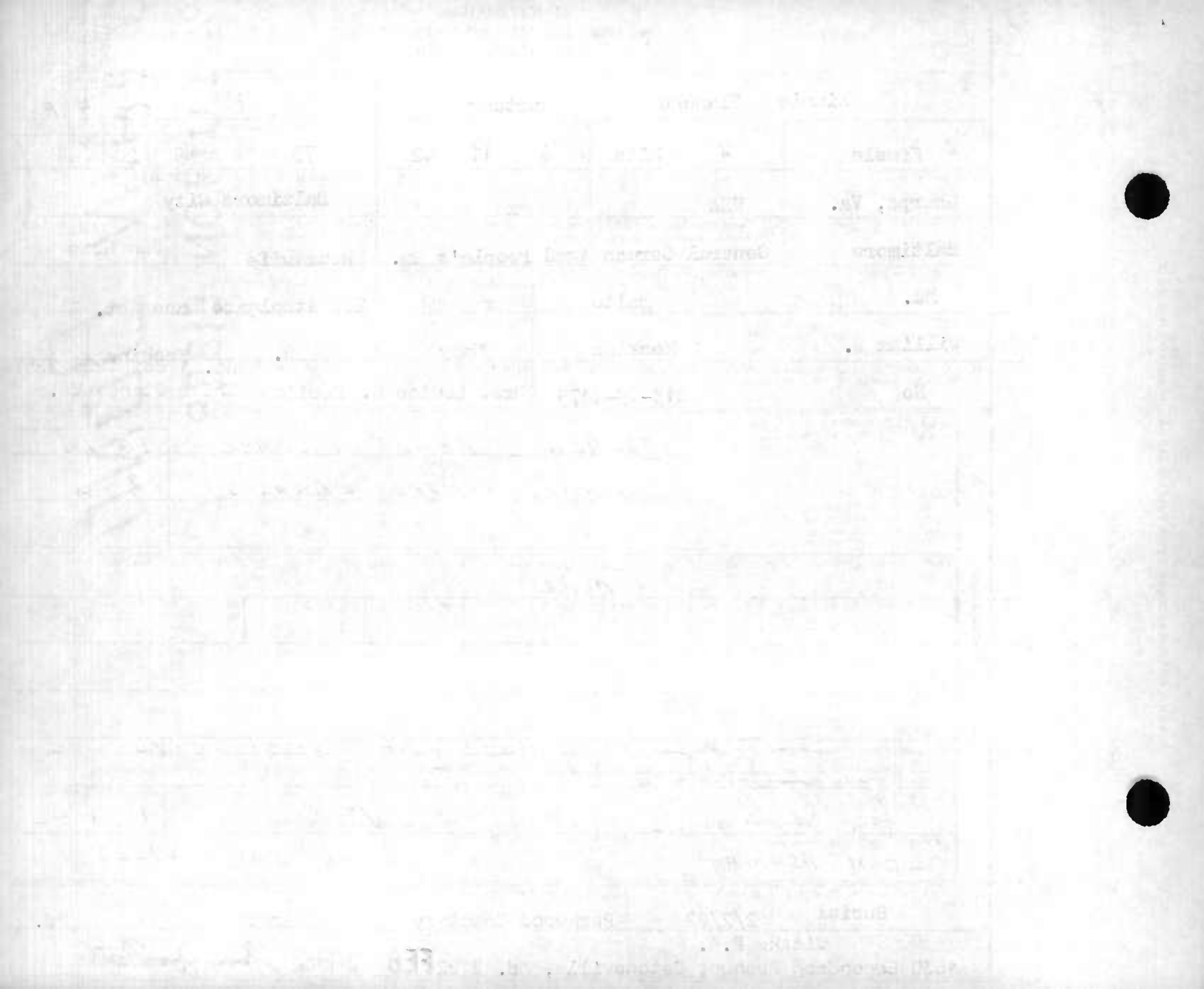
## CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>Minnie Blanche Hartung</b>			2a. DATE OF DEATH MONTH <b>1</b> DAY <b>31</b> YEAR <b>82</b> 2b. HOUR <b>4 A.M.</b>		
3 SEX <b>F Female</b>	4 RACE <b>W White</b>	5. DATE OF BIRTH MONTH <b>4</b> DAY <b>11</b> YEAR <b>02</b>	6 AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS		7. UNDER 1 YEAR MONTHS <b>9</b> DAYS <b>20</b>
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Sharps, Va.</b>	7b CITIZEN OF WHAT COUNTRY? <b>USA</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.		
10 CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>General German Aged People's Hm.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIEE) <b>Housewife</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
13a. STATE <b>Md.</b>			13b. COUNTY <b>Balto</b>	13c. CITY OR TOWN <b>Balto</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME FIRST <b>William Z.</b> MIDDLE <b>Meekins</b> LAST <b>Meekins</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Mary</b> MIDDLE <b>S.</b> LAST <b>Meekins</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>213-09-4475</b>	17 INFORMANT ADDRESS <b>St. 1 Box 1258 22578</b> <b>Mrs. Louise B. Reuling White Stono, Va.</b>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ISCHEMIC HEART DISEASE</b> <b>4140</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CORONARY ATHEROSCLEROSIS</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>?</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 Yrs</b> <b>? Yrs</b>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>NONE</b>					
19a. DATE OF OPERATION <b>NONE</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from <b>JUNE</b> , 19 <b>38</b> , to <b>1-31</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>1-28</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.					
22b. SIGNATURE <b>Leon Ashman</b>		DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1-31-82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>LEON ASHMAN</b>		22e. ADDRESS <b>5907 GWYNN OAK 21207</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>2/2/82</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Baltimore</b>	STATE <b>Md.</b>
24 FUNERAL DIRECTOR NAME <b>Witzke P.A.</b>		ADDRESS <b>1630 Edmondson Avenue, Catonsville, Md. 21228</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 3 1982</b>	





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 0 4 6

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
JEROME		HARTZ		1		21		82	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
MALE		WHITE		FEB. 9, 1927		54		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
MARYLAND		USA		XXX		BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE		JOHNS HOPKINS HOSPITAL				SALESMAN		CEMETERY	
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
MARYLAND						BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS			
MARVIN				HARTZ		7038 WALLIS AVE. #21215			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT			
YES				WWII-A.F.		MR. LOUIS RUTENBERG			
				219-10-4108		7038 WALLIS AVE. BALTO., MD 21215			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a):									
1539 Cardiac Arrest									
DUE TO, OR AS A CONSEQUENCE OF:									
(b) Respiratory Failure									
DUE TO, OR AS A CONSEQUENCE OF:									
(c) Lymphatic Spread of Colonic Adenocarcinoma									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
			P.M. 19						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (his hospital) attended the deceased from 1/14, 1982, to 1/21, 1982, that (I) (we) last saw the deceased alive on 1/21/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE			DEGREE			22c. DATE SIGNED			
Michael Wagner			MD			1/21/82			
22d. PHYSICIAN'S NAME, (TYPE OR PRINT)			22e. ADDRESS						
Michael Wagner			JHH						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
BURIAL			JAN. 22, 1982		OHEB SHALOM MEM. PARK		REISTERSTOWN BALTO. MD		
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
6010 REISTERSTOWN RD. BALTO., MD 21215						JAN 27 1982		James J. Nathan	

15 JAN 55 SSGT P S WAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please retain the original and return it to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 1 0 4 7			
1- FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>FIRST</b> Laura <b>MIDDLE</b> L. <b>LAST</b> Harvey <i>HARVEY LAURA</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>1 10 82</i>		2b. HOUR MIN <i>6 55</i> M	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>3 1 11</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <i>70</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Pennsylvania</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.	
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Baltimore City Hospitals</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homenaker</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <i>Maryland</i>				13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Dundalk</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Bullis</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Not Known</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>072-03-6765</i>		17. INFORMANT ADDRESS <i>Edgar H. Harvey, Jr. 2902 Dunmurry Road Balto. MD 21222</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiovascular Arrest</i> <i>4960</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>COPD</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>1-8</i> 19 <i>82</i> to <i>1-10</i> 19 <i>82</i> , that (I) (we) last saw the deceased alive on <i>1-10</i> 19 <i>82</i> , and that is (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>A Heil MD</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>1-10-82</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>A HEIL MD</i>				22e. ADDRESS <i>Balt City Hosp</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>1/13/82</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Moreland Memorial</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore, Maryland</i>	
24. FUNERAL DIRECTOR NAME ADDRESS <i>Duda-Ruck, Inc. 7922 Wise Avenue, Dundalk, MD 21222</i>				25a. DATE REC'D BY REGISTRAR <i>JAN 14 1982</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Jan Keith</i>	

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RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 0 4 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>REGINA E. HARVEY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>01-06-82</b>		2b. HOUR <b>6:20pm</b>	
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2 17 15</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b> YRS.		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>CHURCH HOME HOSPITAL</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.		
13a. STATE <b>MD</b>			13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Harper</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sarah Evans</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>220-24-1949</b>		17. INFORMANT ADDRESS <b>Arthur C. Harvey 1905 Perlman Place</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b> <b>1991</b> DUE TO, OR AS A CONSEQUENCE OF DEATH <b>CARCINOMA (UNKNOWN SITE) WITH METASTASIS TO BRAIN AND BRAIN</b> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>12-30-</b> to <b>81</b> , to <b>01-06-</b> 19 <b>82</b> , that (I) <input checked="" type="radio"/> saw the death on <b>01-06-</b> 82, and that in (my) <input checked="" type="radio"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="radio"/> did <input type="checkbox"/> did not view the body after death.						
22b. SIGNATURE <b>Sivan</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>1/6/82</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. V. SIVAN M.D.</b>		22e. ADDRESS <b>CHURCH HOSPITAL CORPORATION 100 N. BROADWAY BALTIMORE, MARYLAND 21231</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/12/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore MD</b>		24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H, Inc. 1101 E. North Ave.</b>				
25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <b>JAN 8 1982 [Signature]</b>				

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POST OFFICE

NEW YORK



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Victor</b>			2a. DATE KNOWN OF DEATH EST. MATED <b>XX</b> MONTH DAY YEAR <b>1 1 1982</b>			2b. HOUR M <b>AM</b>	
3. SEX <b>male</b>	4. RACE <b>white</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>9 2 55</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>26</b> YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD <b>1 1 1982</b>	7d. HOUR <b>12:35</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore City Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Draftsman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Lowry Glass</b>
13a. STATE <b>Maryland</b>		13b. COUNTY	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>1405 Broening Highway</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>George</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Maria Kosadok</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Anna M. Hawrylenko 1405 Broening Highway</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute ethanol intoxication</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>Arteriosclerotic Cardiovascular disease</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Hormez R. Guard</b>		TITLE (SPECIFY) <b>Assistant</b>		M.D. MEDICAL EXAMINER		DATE SIGNED <b>1/1/82</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Hormez R. Guard, M.D.</b>		ADDRESS <b>111 Penn Street, Balto, MD 21201</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/5/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Walter Dabrowski</b>				ADDRESS <b>1005 Dundalk Avenue</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 8 1982</b>	
				25b. REGISTRAR'S SIGNATURE <b>James J. Nathan</b>			

Walter J. Brown

1000 Broadway Avenue

Jan 2 1935

Dear Sir

I have

been

informed

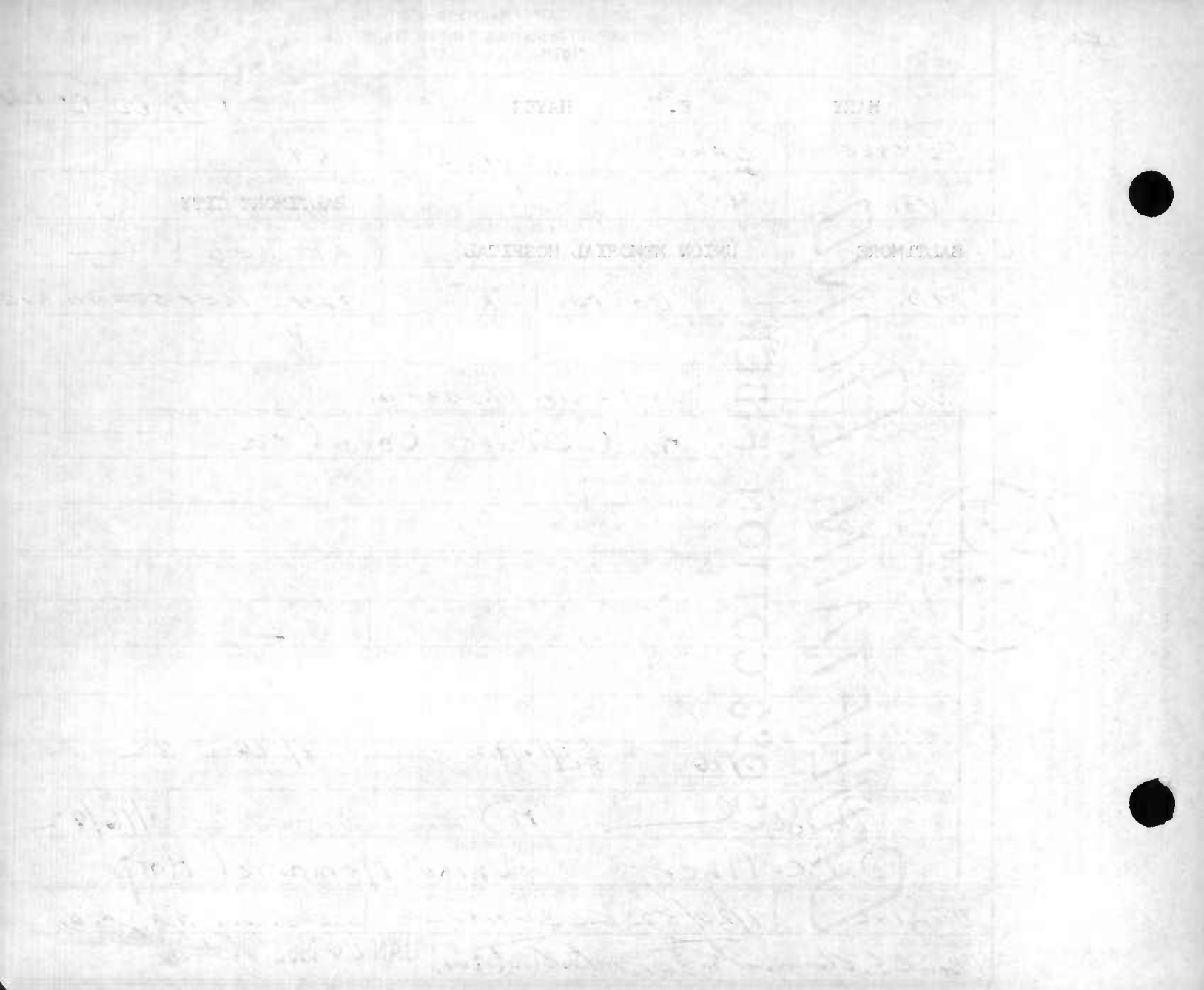
that

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 0 1 0 5 0			
1 - FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
FIRST MARY MIDDLE E. LAST HAYES				MONTH DAY YEAR HOUR 1-16-82 12 midnight			
3. SEX FEMALE		4. RACE CAUC.		5. DATE OF BIRTH MONTH DAY YEAR 11/25/22		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13a. STATE MD.		13b. COUNTY		13c. CITY OR TOWN BALTO.		13e. STREET ADDRESS 3642 KEYSTONE AVE	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 219-22-698		17. INFORMANT ADDRESS HUSBAND.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic bowel ca 1590 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1/16/82, 19 to 1/16, 1982 that (I) (we) lost saw the deceased alive on 1/16, 1982 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE D. Berl DEGREE MD				22c. DATE SIGNED 1/16/82		22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. Berliner	
22e. ADDRESS Union Memorial Hosp				22f. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1/20/82		23c. NAME OF CEMETERY OR CREMATORY GLEN HAVEN		23d. LOCATION CITY OR TOWN COUNTY STATE GLENBURNIE, A.S. MD.	
24. FUNERAL DIRECTOR NAME Paul E. Clamow				25a. DATE REC'D. BY REGISTRAR JAN 20 1982		25b. ADDRESS 3617 Chestnut Ave.	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-338-3900.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 0 1 0 5 1			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
FIRST MIDDLE LAST <b>Hazel Haynie</b>				MONTH DAY YEAR HOUR <b>1-23-82 4:30 PM</b>			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
<b>female</b>		<b>black</b>		MONTH DAY YEAR <b>3 15 97</b>		<b>84</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
<b>Va</b>		<b>USA</b>				<b>Baltimore city MD</b>	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
<b>Baltimore</b>		<b>John L. Deaton</b>					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS?			
13a. STATE 13b. COUNTY 13c. CITY OR TOWN				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>Md Baltimore</b>				<b>2501 W. Mosher Street</b>			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST <b>Salis Hutnell</b>				FIRST MIDDLE LAST <b>Georgeanna Dunaway</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
<b>NO</b>				<b>N/A</b>		<b>Mae Boardley 2501 W. Mosher Street</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <b>C.V.A. - 7 months</b>							
DUE TO, OR AS A CONSEQUENCE OF (b) <b>U.T. I. - 7 months</b>							
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Decubitus ulcers 7 months</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>3/11/81</b> 19 <b>81</b> to <b>Jan 23</b> 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>Jan 23 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
<b>Paul Schmeckel MD</b>						<b>1/24/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
<b>Paul Schmeckel MD</b>				<b>457 Ocean Highway</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
<b>Burial</b>		<b>1/30/82</b>		<b>Arbutus Mem Park</b>		<b>Arbutus Md</b>	
24. FUNERAL DIRECTOR NAME ADDRESS				25a. DATE REC'D. BY REGISTRAR SIGNATURE			
<b>William C. March F/H 1101 E. North Ave</b>				<b>JAN. 26 1982 Frances Jan. Nathan</b>			

10-10-11

10-10-11

10-10-11

10-10-11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

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FOR  
1 - STATE  
REGISTRAR

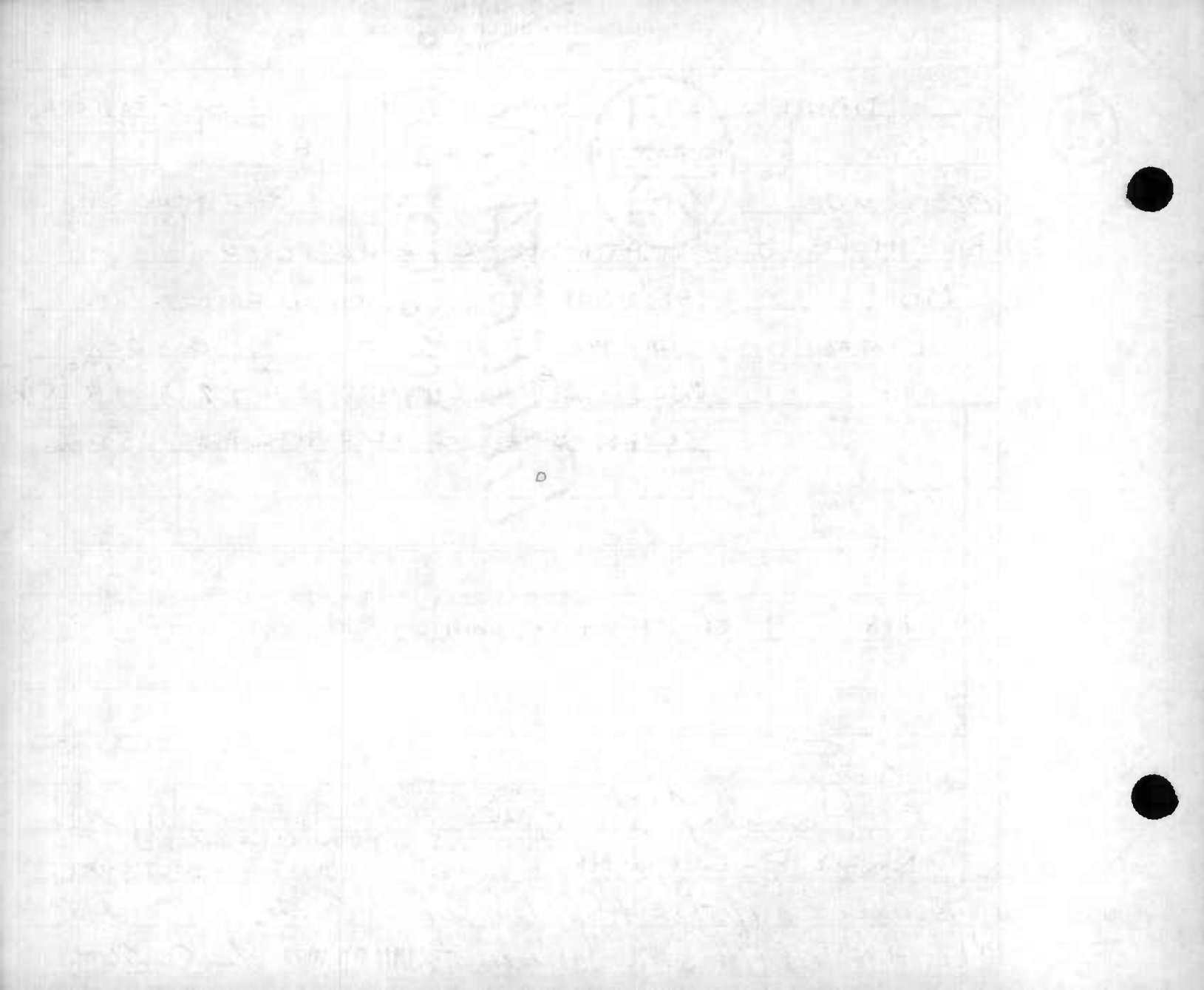
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 0 5 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) DANIEL L. HAYWOOD Jr.			2a. DATE OF DEATH MONTH DAY YEAR 1 - 13 - 82			2b. HOUR 11:02 A.M.	
3. SEX M		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 5 - 13 - 18		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTO. M.O.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) J.L. DEATON MEDICAL CTR				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MUSICIAN	
13a. STATE MD		13b. COUNTY BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1016 W. FAYETTE ST.	
14. FATHER'S NAME FIRST MIDDLE LAST DANIEL HAYWOOD				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LOETTA GOLDEN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) UNK.		16b. SOCIAL SECURITY NO. 215-05-8220		17. INFORMANT DANIEL L. HAYWOOD III		ADDRESS 828 Druid PK. Lk. Dr.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1489 SQUAMOUS CELL CA. OF HYPOPHARYNX DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 mos.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).							
19a. DATE OF OPERATION 1/80		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CA. OF HYPOPHARYNX			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1/11, 19 82, to 1/15, 19 82, that (I) (we) last saw the deceased alive on 1/13, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Donald R. Lurye, MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/13/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DONALD R. LURYE, MD				22e. ADDRESS J.L. DEATON MED. CTR. 611 S. CHARLES ST. BALTIMORE			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/15/82		23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.	
24. FUNERAL DIRECTOR NAME Chas. H. Powell F/H 319 N. Schroeder St.				25a. DATE REC'D. BY REGISTRAR JAN 20 1982		25b. REGISTRAR'S SIGNATURE James J. Martin	





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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 0 1 0 5 3			
1 - FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
FIRST MIDDLE LAST ROLAND ANDERSON HAZELL				MONTH DAY YEAR 01 / 01 / 82			
3. SEX MALE				2b. HOUR 08:45A			
4 RACE CAUCASIAN		5. DATE OF BIRTH JULY 4, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 74		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) DELAWARE		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) EXECUTIVE		12b. KIND OF BUSINESS OR INDUSTRY CRANE CO. WHSLE. PLUMBING	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13e. STREET ADDRESS 6314 GREENSPRING AVE., APT. 305	
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA OAKS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 172-03-9907		17. INFORMANT MRS. BERTHA HAZELL 6314 GREENSPRING AVE., APT. 305 #21209			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1610 DUE TO, OR AS A CONSEQUENCE OF (b) Anoxic Encephalopathy (ENCEPHALOPATHY) Carbuncle of Vocal cord DUE TO, OR AS A CONSEQUENCE OF (c) 10 days				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) Johns Hopkins		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/30, 19 81, to 1/1, 19 82, that (I) (we) last saw the deceased alive on 1/1/82, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Patrick Ma				DEGREE MB, BCh BAO, BA MA, LACP MRCs ATTENDING MEDICAL STAFF PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/1/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PATRICK MA				22e. ADDRESS Johns Hopkins Hospital, Dept of Medicine			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1-3-82		23c. NAME OF CEMETERY OR CREMATORY OHEB SHALOM MEM. PARK		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD	
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD., BALTO., MD 21215				25a. DATE REC'D. BY REGISTRAR JAN 7 1982		25b. REGISTRAR'S SIGNATURE James J. Nathan	

BP

1905 JAN 5

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 0 1 0 5 4			
1- FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>FRANCES A. HEIL</b> <i>FRANCES HEIL</i>				2a. DATE OF DEATH MONTH DAY YEAR <b>JAN 4 82</b>		2b. HOUR <b>1:05 PM</b>	
3 SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 07 04</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A..</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Balto City</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Good Samaritan Hosp</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Practical Nurse</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Medical</b>	
13a. STATE <b>Maryland</b>				13b. CITY OR TOWN <b>Baltimore</b>		13c. STREET ADDRESS <b>1719 E. Northern Pkwy</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Albert Rodgers</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Permelia Melone</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>216-28-2481</b>		17. INFORMANT ADDRESS <b>William L. Heil Baltimore, MD 21239</b>	
18. CAUSE OF DEATH *Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-Respiratory Arrest</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>REFRACTORY CHF</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>MI - Biventricular dilatation</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>Oct 5 81</b> to <b>Jan 4 82</b> , that (I) (we) last saw the deceased alive on <b>Jan 3 82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Roma Rosa</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>Jan 4, 1982</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ROMULO DELA ROSA</b>				22e. ADDRESS <b>GOOD SAMARITAN HOSPITAL</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Jan. 7, '82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Mem. Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Co., MD</b>	
24. FUNERAL DIRECTOR NAME <b>William E. Johnson</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 5 1982</b>		25b. REGISTRAR'S SIGNATURE <i>William E. Johnson</i>	
ADDRESS <b>8521 Loch Raven Blvd.</b>							



*[Faint, illegible text spanning the main body of the page, likely bleed-through from the reverse side.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of age.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8201055	
1. FOR STATE REGISTRAR						2a. DATE OF DEATH					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARGARET T HELFRICH						MONTH DAY YEAR 1 5 82		2b. HOUR 155		M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12 24 96		6. AGE (IN YEARS, LAST BIRTHDAY) 85 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR INDUSTRY Govt.			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.						13b. COUNTY A.A.		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John J. Helfrich						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary E. Allan					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No						16b. SOCIAL SECURITY NO. 218-09-9988		17. INFORMANT ADDRESS Margaret Ziegler - Sec. 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 4100 DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 12/30/81 to 1/5/82, that (I) (we) last saw the deceased alive on 1/5/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE K. C. Lunge MD						22c. DEGREE MD		22d. DATE SIGNED 1/5/82		22e. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22f. PHYSICIAN'S NAME (TYPE OR PRINT) Lunge						22g. ADDRESS Mercy Hosp. Balto. MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 1-7-82		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Mem		23d. LOCATION CITY OR TOWN COUNTY STATE Dulaney Valley Balto MD.			
24. FUNERAL DIRECTOR NAME Robert S. Barranco						ADDRESS 501 Ritchie Ave Severna Park MD		25a. DATE REGD. BY REGISTRAR JAN 11 1982			
								25b. REGISTRAR'S SIGNATURE Frances Jean Nathan			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the room after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 0 5 6

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>FAYE M HEMP</b>			2a. DATE OF DEATH MONTH <b>1</b> DAY <b>31</b> YEAR <b>82</b>			2b. HOUR <b>A</b> <b>11 15</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>9</b> DAY <b>22</b> YEAR <b>08</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Agnes Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Food</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Arbutus</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>5001 Westland Blvd.</b>				
14. FATHER'S NAME FIRST <b>Unknown</b> MIDDLE <b></b> LAST <b>Pearson</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Florence</b> MIDDLE <b></b> LAST <b>Unknown</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>214-03-4438</b>		17. INFORMANT ADDRESS <b>908 Jamieson Rd.</b> <b>Mr. L. Brenton Hemp Lutherville, Md. 21093</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CIRCULATORY SHOCK</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>gram-NEGATIVE SEPTICAEMIA</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ORTHA PNEUMONIA</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 DAYS</b> <b>5 DAYS</b> <b>1 WEEK</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>ALCOHOLIC LIVER DISEASE</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>1/22/1982</b> to <b>1/31/1982</b> , that (I) (we) last saw the deceased alive on <b>1/31/1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>[Signature]</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>1/31/82</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>CORNELIS HALMA</b>				22e. ADDRESS <b>ST. AGNES HOSPITAL</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2/3/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Mausoleum</b>		23d. LOCATION CITY OR TOWN <b>Baltimore</b> COUNTY <b></b> STATE <b>Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Witzke P.A.</b> ADDRESS <b>1630 Edmondson Avenue, Catonsville, Md. 21228</b>				25a. DATE REC'D. BY REGISTRAR <b>FEB 3 1982</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

DHMH-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 1 0 5 7			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>ELIZABETH J. HENDERSON</b>				2a. DATE OF DEATH MONTH <b>1</b> DAY <b>1</b> YEAR <b>82</b>		2b. HOUR <b>2:20 AM</b>	
3 SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH <b>12</b> DAY <b>3</b> YEAR <b>1902</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNION MEMORIAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret. Principal</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>City</b>	
13a. STATE <b>Maryland</b>				13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>	
14. FATHER'S NAME FIRST <b>Oscar</b> MIDDLE LAST <b>Johnson</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Mary</b> MIDDLE LAST <b>Jaques</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>214-40-5700A</b>		17. INFORMANT <b>Baltimore, Md. 21217 Ave.</b> <b>Mr. Paul S. Henderson 1925 Druid Hill</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBROVASCULAR ACCIDENT WITH PSEUDOBULBAR PALSY</b> <b>4360</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>DIABETES MELLITUS</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>12/19</b> , 19 <b>81</b> , to <b>1/1</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>1/1/82</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Serald Ward</b> M.D.				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1/1/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SERALD WARD</b>				22e. ADDRESS <b>UNION MEMORIAL HOSP.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/5/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Mem. Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore County, Md.</b>	
24. FUNERAL DIRECTOR NAME <b>HERBERT E. NUTTER</b> ADDRESS <b>BALTIMORE, MD 21218</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 5 1982</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. [Signature]</b>	

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 0 5 8

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Hendrix Allen A. HENDRIX		2a. DATE OF DEATH MONTH DAY YEAR 4 22 82		2b. HOUR 1:28 PM	
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 9/16/16	6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS	7. IF UNDER 1 YEAR MONTH DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GA.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <del>DELMA</del> BALTO. CITY MD.		
10. CITY OR TOWN OF DEATH BALTO	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTO CITY HOSP.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) STEEL L		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.		13b. CITY OR TOWN BALTO	13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13d. STREET ADDRESS 9 BROADSHIP RD.	
14. FATHER'S NAME FIRST MIDDLE LAST UNK		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNK			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) UNK		16b. SOCIAL SECURITY NO. 260 18 6772	17. INFORMANT ADDRESS DELMA HENDRIX 9 BROADSHIP RD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio pulmonary arrest</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Congestive heart failure, emphysema</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>1/19</u> , 19 <u>82</u> , to <u>1/22</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>1/22</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Bruce Kinsian</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Bruce Kinsian		22e. ADDRESS BCH			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 1/26/82	23c. NAME OF CEMETERY OR CREMATORY MEADOW RIDGE		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD.	
24. FUNERAL DIRECTOR NAME J. E. CONNELLY		ADDRESS 300 MACE		25a. DATE REC'D. BY REGISTRAR JAN 29 1982	25b. REGISTRAR'S SIGNATURE <u>Charles J. Kinsian</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 0 5 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>MARTIN F. HENNIGAN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>January 17, 1982</b>		2b. HOUR <b>1230</b> M
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>February 11, 1897</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b>	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>7002 Old Harford Road</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Stationary Engineer</b>	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Edward Hennigan</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ann Melvin</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES] <b>Yes WW 1</b>		16b. SOCIAL SECURITY NO. <b>195-10-9125</b>		17. INFORMANT ADDRESS <b>Mrs. Mary Cale 3161 Woodring Avenue</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Calcinozoma of the mandible</b> <b>1701</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>March 19 81</b> to <b>Jan 17 19 82</b> , that (I) (we) last saw the deceased alive on <b>Dec 12 19 81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>William H. Fusting, M.D.</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>1-19-82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>William H. Fusting, M.D.</b>		22e. ADDRESS <b>300 Ridgely Road</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>1-19-1982</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Leonard J. Ruck, Inc. 5305 Harford Road 2214</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 19 1982</b>		25b. REGISTRAR'S SIGNATURE <b>James J. Nathan</b>	



SECRET JAN 1985



SECRET

CONFIDENTIAL

RELEASED ON APPROVAL BY MEDICAL EXAMINER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and the medical certification must be completed.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 1 0 6 0			
1. FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
Harvey		H.		Hensen				1		12	82	8	PM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. UNDER 1 YEAR		8. UNDER 2 YEARS			
Male		Black		9 MONTH 6 DAY 96		85		YRS		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
MD		USA				Baltimore City						MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Baltimore		City Hospital											
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
MD				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2314 E. Madison St.					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
FIRST MIDDLE LAST		FIRST MIDDLE LAST											
Horace H. Henson		Maggie Cullison											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS							
Yes		N/A		Julia Crew		2319 E. Madison St.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) 8903 Massive (73%) 2° & 3° burns										10 hrs.			
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last													
DUE TO, OR AS A CONSEQUENCE OF													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
<input checked="" type="checkbox"/>		8:51 PM 1 12 82		House Fire									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
At home				2314 E. Madison Balt. MD									
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 1/12/1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED		1/12/82	
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>									
M. Nelson M.D.													
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
Nelson		Balt City Hosp											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial		1/19/82		Md. Veteran Cem.		Crownsville MD							
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Wm. C. March F/H		1101 E. North Ave.		JAN 18 1982		Name							

10/10/11

11

10/10/11

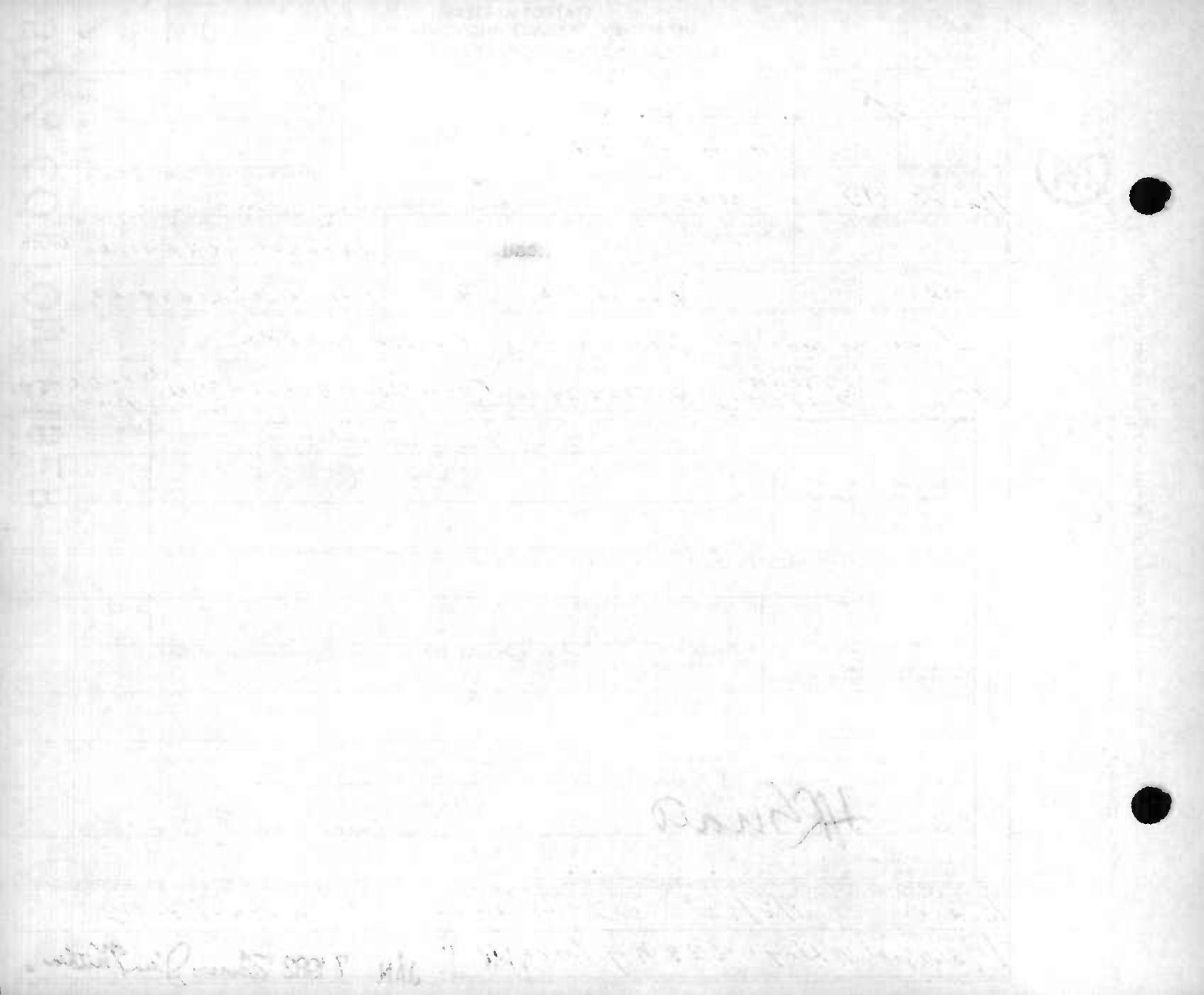
10/10/11

10/10/11

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. IF THE DEATH IS SUSPECTED, PAGE 6 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. IF THE DEATH IS SUSPECTED, PAGE 6 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. IF THE DEATH IS SUSPECTED, PAGE 6 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 7201061	
1. DECEASED NAME (TYPE OR PRINT) <b>John W. Henson, Jr. (Henderson)</b>						2a. DATE KNOWN OF DEATH MONTH DAY YEAR <b>1 4 1982</b>		2b. HOUR M <b>1</b>			
3. SEX <b>male</b>		4. RACE <b>black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4 7 27</b>		6. AGE (IN YEARS) (LAST BIRTHDAY) <b>54</b> YRS.		7. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>1 4 1982</b>		2d. HOUR M <b>1</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>BALTO MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3711 Woodridge Road</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SALES MANAGER WKS</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>MD</b>				13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3711 WOODRIDGE RD</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John W. Henson Henderson</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Callie G. GORDON</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>yes</b>				16b. SOCIAL SECURITY NO. <b>215-22-3942</b>		17. INFORMANT ADDRESS <b>BURN HENDERSON 3711 WOODRIDGE RD</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive cardiovascular disease</b> 4029 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>H. R. Guard</b>				TITLE (SPECIFY) <b>Assistant</b>				DATE SIGNED <b>1/4/82</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Hormez R. Guard, M.D.</b>				ADDRESS <b>111 Penn Street, Balto, MD</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>				23b. DATE <b>1/5/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MD VERMONT</b>		23d. LOCATION (CITY OR TOWN) COUNTY STATE <b>BALTIMORE CITY MD</b>			
24. FUNERAL DIRECTOR NAME <b>James R. Hays</b> ADDRESS <b>638 N. 9th St</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 7 1982</b>		25b. REGISTRAR'S SIGNATURE <b>James R. Hays</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. (Reg. 4 may be retained by the hospital or attending physician.)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 0 6 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Frank G Hessler</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1 1 21 82</b>			2b. HOUR <b>9<sup>07</sup> AM</b>				
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4 23 01</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto. City</b> MD.				
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>The Good Samaritan</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Accountant</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>B</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>Balt., Md. 21213 2233 PELHAM AVE.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Frank A. Hessler</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Philomena Albrecht</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>212-05-7884</b>		17. INFORMANT <b>Son:</b>		ADDRESS <b>Balt., Md. 21234 Ralph P. Hessler 1336 Kenton Road</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Renal failure</b> <b>5849</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>12/05/81</b> , 19____, to <b>1/21/82</b> , 19____, that (I) (we) lost saw the deceased alive on <b>1/20</b> , 19 <b>82</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Rajan Sood</b>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1/21</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RAJAN SOOD</b>						22e. ADDRESS <b>GOOD SAMARITAN HOSPITAL</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Jan 25 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Most Holy Redeemer</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Leonard J. Ruck, Inc. Baltimore, Maryland</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 22 1982</b>		25b. REGISTRAR'S SIGNATURE <b>James J. Nathan</b>		





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR					8 2 0 1 0 6 3 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
FIRST MIDDLE LAST ANDREW HETMANSKI					MONTH DAY YEAR HOUR 1 30 82 12 <sup>5</sup> PM				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
male		white		MONTH DAY YEAR August 15, 1913		68 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		USA				Baltimore City MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		Mercy Hospital				laborer		steel mill	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13b. INSIDE CITY LIMITS?				
13a. STATE COUNTY Maryland					13b. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
13c. CITY OR TOWN Baltimore					13e. STREET ADDRESS 1213 Light Street				
14. FATHER'S NAME FIRST MIDDLE LAST unknown					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST unknown				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
unknown					218-05-5656		Federal Hill Nursing Home 1213 Light St. Bal.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) PNEUMONIA									1 WK
4360 DUE TO, OR AS A CONSEQUENCE OF (b) CEREBROVASCULAR ACCIDENT									1 WK
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) CHRONIC DEMENTIA									YEARS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CHRONIC DEMENTIA									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from 1/29, 19 82, to 1/30, 19 82, that (we) lost saw the deceased alive on 1/30, 19 82, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					DEGREE		HOUSE STAFF <input checked="" type="checkbox"/> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED
R. MAGGIN					MD				1/30/82
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
R. MAGGIN					MERCY HOSPITAL, BALTO, MD.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial			Feb. 4, 1982		Sacred Heart of Jesus Cem.		Baltimore Co. Md.		
24. FUNERAL DIRECTOR NAME					25. DATE REC'D. BY REGISTRAR				
Mitchell-Wiedefeld Home 6500 York Rd. Bal. Md.					FEB 5 1982				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>TILLIE HEYMAN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JAN. 4, 1982</b>			2b. HOUR <b>7:01P M</b>			
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>OCT. 17, 1916</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS <b>65</b>		IF UNDER 1 YEAR IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY MD.</b>			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>6514 EBERLE DR. APT. 202 (21215)</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>MORRIS HEYMAN</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>FANNIE UNKNOWN</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			
16b. SOCIAL SECURITY NO. <b>218-10-3122</b>			17. INFORMANT ADDRESS <b>HARRY LICHTER 2403 LIGHTFOOT DR. (21209)</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>4149 Sudden death of uncertain etiology</b> IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest (unrelated to trauma) 4/3</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cornary Artery Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Coronary Artery Disease</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minute</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 1a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>11/3</b> , 19 <b>81</b> , to <b>1/4</b> , 19 <b>81</b> , that (I) (we) lost the deceased alive on <b>1/4</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Richard Stephenson</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1-5-82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RICHARD STEPHENSON</b>			22e. ADDRESS <b>SINAI HOSPITAL</b>						
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>			23b. DATE <b>1/5/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SWINICHER WOLINER</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE, MD.</b>		
24. FUNERAL DIRECTOR NAME <b>S OL LEVINSON &amp; BROS</b>			24b. ADDRESS NAME <b>6010 REISTERSTOWN RD. BALTIMORE, MD. (21215)</b>			25a. DATE REC'D. BY REGISTRAR <b>JAN 7 1982</b>		25b. REGISTRAR'S SIGNATURE <b>James J. Smith</b>	



Received from the  
Hon. Secy. of the Navy  
the sum of \$100.00  
for the purchase of  
the sum of \$100.00

Wm. J. [Signature]

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 0 6 5

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Susie A HICKS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1 28 82</b>		2b. HOUR <b>425 P.M.</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>7 7 05</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St Agnes Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Manager</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Drive in Rest</b>
13a. STATE <b>Md</b>			13b. COUNTY <b>-</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Lawson Hall</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna Butler</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>219 26 1685A</b>		17. INFORMANT ADDRESS <b>Joseph B. Hicks Jr. Same</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b> 4100 } DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute Extensive Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>one week</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30 minutes</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 11a <b>Acute Cerebrovascular Accident with Left Hemiparesis</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 21, 19 82</b> , to <b>Jan 28, 19 82</b> , that (I) (we) last saw the deceased alive on <b>Jan 28, 19 82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Jeffrey J. Cole, M.D.</b>		DEGREE		22c. DATE SIGNED <b>1/28/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>J. Cole, M.D.</b>		22e. ADDRESS <b>3455 Wilkens Ave. Balt Md. 21229</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2/1/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Woodlawn Balto. Co. Md.</b>		24. FUNERAL DIRECTOR <b>Burgee Funeral Home 3631 Falls Road 21211</b>			
25a. DATE REC'D. BY REGISTRAR'S SIGNATURE <b>FEB 1 1982</b>		25b. DATE REC'D. BY REGISTRAR'S SIGNATURE <b>Frances J. [Signature]</b>			

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 1  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 0 6 6

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>GIRL</b> <b>HIGGINS</b> <b>"A"</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Jan. 1 1982</b>		2b. HOUR <b>2:30 PM</b>
3. SEX <b>FEMALE</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>1 1 82</b>		6. AGE (IN YEARS AND BIRTHDAY) <b>0</b> YRS. MONTHS DAYS HOURS MIN. <b>22</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Mercy Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE <b>MD</b> COUNTY <b>MD</b>			13b. CITY OR TOWN	13c. STREET ADDRESS <b>3310 Elm Ave.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Kevin P. Higgins</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Anne Quinn Higgins</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b> <b>7798</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Severe Immaturity</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>1-1-82</b> to <b>1-1-82</b> , that (I) (we) last saw the deceased alive on <b>1-1-82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
72b. SIGNATURE <b>Patricia L. Steadman</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>1-5-82</b>	
72d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>PATRICIA L. STEADMAN</b>		22e. ADDRESS <b>301 St. Paul Pl. Md. 21202</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>		23b. DATE <b>1-7-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GREENMOUNT</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALD. MD</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>MITCHELL-WIEDEFELD 6500 YORK RD Z1212</b>			
25. DATE OF DEATH BY REGISTRAR <b>JAN 12 1982</b>		26. REGISTRAR'S SIGNATURE <b>Charles J. Nathan</b>			



JAN 2 1985  
JAN 2 1985  
JAN 2 1985

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 2 0 1 0 6 7	
1. FOR STATE REGISTRAR					CERTIFICATE OF DEATH						
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					2b. HOUR	
GIRL					HIGGINS "B"					1-1-82	2 AM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		W		MONTH DAY YEAR 1 1 82		0 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Md.		U.S.				Baltimore City MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Baltimore		Murray Hospital									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
Md.								3310 Elm St.			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST Kevin P Higgins				FIRST MIDDLE LAST Mary Anne Higgins							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> 7798 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Extreme immaturity</u> (c) <u></u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 1-1-82, to 1-1-82, that (I) (we) last saw the deceased alive on 1-1-82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						DEGREE		22c. DATE SIGNED			
Patricia L. Saloara						M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		1-5-82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS					
PATRICIA L. SALOARA						301 St. Paul Pl. Md. 21202					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Cremation		1-7-82		GREENMOUNT		BALD COUNTY MD					
24. FUNERAL DIRECTOR NAME ADDRESS						25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE					
MITCHELL-WIEDERLID 6300 YORK RD.						JAN 12 1982 Charles J. Nathan					

RECEIVED  
JAN 10 1963

RECEIVED  
JAN 10 1963

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JAN 10 1963

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 1 0 6 8			
1. FOR STATE REGISTRAR										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LOUISE MORSE HIGGINS						2a. DATE OF DEATH MONTH DAY YEAR 1 5 82				2b. HOUR 749 P.M.			
3. SEX Female		4. RACE CAUC		5. DATE OF BIRTH MONTH DAY YEAR 9 18 13		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 74 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BACTO. CITY MD.							
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GOOD SAMARITAN HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MARYLAND P.G.		13c. CITY OR TOWN BRANDYWINE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 14108 Brandywine Hgts Road							
14. FATHER'S NAME FIRST MIDDLE LAST Edward Franklin Morse				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha F. Maddera									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 578 32 4690		17. INFORMANT Katherine M. Garlick		ADDRESS P.O. Box 71 Glenwood, Fla.							
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u> 4151 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) <u>PULMONARY EMBOLUS</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a <u>RHEUMATOID ARTHRITIS AMYLOIDOSIS CIRCULATING ANTICOAGULANT CHRONIC RENAL FAILURE</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? TO BE DONE YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (1) this hospital attended the deceased from 12/19 19 81, to 1/5 19 82, that (2) we lost above, (3) we (did) (did not) view the body after death, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated													
22b. SIGNATURE Cynn M. Billingsley MD.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 1/5/82					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CINN M. BILLINGSLEY MD.				22e. ADDRESS GOOD SAMARITAN HOSPITAL 5601 LOCH RAVEN BLVD. BALTO. MD. 21239									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-11-82		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, P.G. Maryland							
24. FUNERAL DIRECTOR Hunt Funeral Home, Waldorf, Maryland						25a. DATE OF RECORD MADE JAN 13 1982		25b. REGISTRAR'S SIGNATURE [Signature]					

MEDICAL CERTIFICATION



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner (must) be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

B 2 0 1 0 6 9

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Fredricka L. Hildebrand</b>			2a. DATE OF DEATH MONTH <b>1</b> DAY <b>25</b> YEAR <b>82</b>			2b. HOUR <b>M</b>				
3. SEX <b>Female</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH <b>5</b> DAY <b>28</b> YEAR <b>1922</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>59</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WASHINGTON, D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD				
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>4937 WEST HILL ROAD</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret. School Teacher</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Balto City</b>		
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. STREET ADDRESS <b>4937 WEST HILL RD. BALTIMORE, MARYLAND 21229</b>			
14. FATHER'S NAME FIRST <b>Rev. Augustus</b> MIDDLE <b>Lewis</b> LAST <b>Lewis</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Emma</b> MIDDLE <b>DAVIS</b> LAST <b>DAVIS</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>579-20-6510</b>		17. INFORMANT <b>Rev. Walter L. Hildebrand</b>				ADDRESS <b>BALTO. MD. 21229 Rd. 4937 West Hill</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>1749</b> IMMEDIATE CAUSE (a) <b>Metastatic Breast Cancer</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b></b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 years</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a										
19a. DATE OF OPERATION <b>9/22</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>EC</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>9/22</b> , 19 <b>82</b> , to <b>1/6</b> , 19 <b>82</b> , that (a) we lost saw the deceased alive on <b>1/6</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>S. Milner, MD</b>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>1/25/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. Sheldon Milner</b>			22e. ADDRESS <b>Old Court Prof. Bldg. Suite 105</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>1-29-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Memorial Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>WASHINGTON, D.C.</b>			
24. FUNERAL DIRECTOR NAME <b>BALTIMORE</b>			ADDRESS <b>MARYLAND 21216</b>			25a. DATE REC'D. BY REGISTRAR <b>JAN 27 1982</b>		25b. REGISTRAR'S SIGNATURE <b>Thomas J. Thornton</b>		
HERBERT E. NUTTER FUNERAL HOME 3035 W. NORTH AVE.										

MEDICAL CERTIFICATION

9  
9

2834 BP







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 0 7 0

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		BABY BOY 'A' ISAAC M. HILL		JANUARY 9 1982		7:40 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male	Black	MONTH DAY YEAR 12 30 81	YRS	MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH				
BALTO., Md.	U.S.A.		CITY MD.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
BALTO	ST. AGNES		INFANT				
13a. STATE		13b. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS			
Md.		Salisbury	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	P.O. Box 2093			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST MARTY Hill		FIRST MIDDLE LAST Judith Ann WAITERS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS				
N/A		NONE	Mr. Marty Hill P.O. Box 2093 Salisbury, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INTRACEREBRAL HEMORRHAGE 7690 DUE TO, OR AS A CONSEQUENCE OF (b) RESPIRATORY DISTRESS SYNDROME Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		22c. DATE SIGNED			
BERT F. MORTON		M.D.		JAN 10 1982			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
BERT F. MORTON		900 CATON AVE. BALTIMORE MD 21229					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY			
Burial		1-13-82	KING MEM PK.	BALTIMORE MD			
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR AND REGISTRAR'S SIGNATURE			
JAS. A. MORTON & SONS		1701 LAURENS		JAN 12 1982			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 2 0 1 0 7 1 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Rachel Bell Hill</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1 29 82</b>		2b. HOUR <b>555A</b>
3. SEX <b>FEMALE</b>	4. RACE <b>BLACK</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>1 11 00</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>SUSSEX CO VA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO. CITY MD.</b>	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BALTO CITY HOSPITAL</b>		12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SEWING MACHINE</b>	
13a. STATE <b>MD</b>		13b. COUNTY <b>BALTIMORE</b>		13c. STREET ADDRESS <b>3101 VIRGINIA AVE</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>UNKNOWN</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>CHERRY LONDA</b>		17. INFORMANT <b>NANNIE SATTERWHITE</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES)		17. ADDRESS <b>3101 VIRGINIA AVE</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio pulmonary arrest</b> <b>1629</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Sepsis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Metastatic Squamous Lung Ca</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>12-26</b> 19 <b>81</b> to <b>1-29</b> 19 <b>82</b> , that (I) (we) lost saw the deceased alive on above, (I) (we) did (did not) view the body after death.					
22b. SIGNATURE <b>William A. Dombrowski</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>1-29-82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>WM DOMBROWSKI</b>		22e. ADDRESS <b>BALTO CITY HOSPITALS</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>1/31/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Hope Bury</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>SUSSEX CO VA</b>		23e. DATE REC'D. BY REGISTRAR <b>FEB 1 1982</b>		23f. REGISTRAR'S SIGNATURE <b>Thom J. [Signature]</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Thomson &amp; Sons 638 9th St</b>					

Dear Sir,

I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the above named matter.

I am sorry to hear that you are not satisfied with the result of the investigation.

I have been very busy lately, and have not had time to attend to this matter as soon as I wished.

I am, Sir, very respectfully,  
Yours,  
W. H. & C. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified of source.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 1 0 7 2 REG. NO.			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) <b>BETTY Louise HINE</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>JANUARY 27 1982</b> 2b. HOUR <b>10:40A</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 5, 1933</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>48</b> YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore, Maryland</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>JOHNS HOPKINS HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Penna.</b>				13b. COUNTY <b>Fulton</b>		13c. CITY OR TOWN <b>Harrisonville</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>George A. Selkirk</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Norma Jean Fox Selkirk</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>132 28 8515</b>		17. INFORMANT ADDRESS <b>William G. Hine, RD1, Box 934, Harrisonville, Pa. 17228</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO RESPIRATORY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CARCINOMA OF THE LUNG</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>1629</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 mins</b> <b>15 mos.</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) <del>(the hospital)</del> attended the deceased from <b>Oct</b> , 19 <b>80</b> , to <b>Jan</b> , 19 <b>82</b> , that (1) <del>(we)</del> last saw the deceased alive on <b>Jan 27</b> , 19 <b>82</b> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (1) <del>(we)</del> (did) <del>(did not)</del> view the body after death.							
22b. SIGNATURE <b>W. G. Mues McKenna M.D.</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>Jan 27, 1982</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MCKENNA</b>				22e. ADDRESS <b>Johns Hopkins Hospital, Baltimore.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>30 January 82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Siloam United Methodist</b>		23d. LOCATION <b>Harrisonville, Fulton, Penna.</b>	
24. FUNERAL DIRECTOR NAME <b>Howard L. Spies</b>		S.R.3, Box 7 Harrisonville, Pa. 17228		25. DATE RECD. BY REGISTRAR <b>FEB 2 1982</b>		26. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

[illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, there should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Kathryn Mary Hofferbert</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>1-5-82</i>		2b. HOUR <i>6:20P.</i> M.	
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MC/YR YEAR <i>11-5-1891</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>91</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (COUNTRY) <i>Balto. Md.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.		
10. CITY OR TOWN OF DEATH <i>Balto.</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HOSPITAL, GIVE STREET ADDRESS) <i>2002 Swansea Rd.</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Seamstress</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						
13a. STATE <i>Md.</i>	13b. COUNTY	13c. CITY OR TOWN <i>Baltimore</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <i>2002 Swansea Rd. -21239</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>Frank Grau</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Elizabeth</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>213-09-9242</i>		17. INFORMANT ADDRESS <i>Miss Elizabeth M. Hofferbert - 2002 Swansea Rd.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebrovascular Accident</i> <i>4360</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>10-22</i> 19 <i>78</i> , to <i>1-5</i> 19 <i>82</i> , that (I) <del>we</del> lost saw the deceased alive on <i>10-22</i> 19 <i>78</i> , and that in (my) <del>our</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>we</del> <i>did</i> (did not) view the body after death.						
22b. SIGNATURE <i>Marvin C. Kowalewski MD</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>1-7-82</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>8604 HARFORD Rd</i>		22e. ADDRESS <i>M.C. KOWALEWSKI MD</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>1-9-82</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer Cem.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Balto. Md.</i>
24. FUNERAL DIRECTOR NAME <i>John C. Miller Inc-6415 Belair Rd.-21206</i>				25a. DATE REC'D. BY REGISTRAR JAN 8 1982 REGISTRAR'S SIGNATURE <i>Thomas J. [Signature]</i>		





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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 0 7 4

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		MONTH DAY YEAR	
FIRST MIDDLE LAST		January 30, '82		9:03A M	
Mattie Holder					
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Female	Black	8 MONTH 21 DAY 08 YEAR	73	IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
VA		USA		9. BALTIMORE CITY OR COUNTY OF DEATH	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Baltimore		Maryland General Hospital		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
MD				Baltimore	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS	
FIRST MIDDLE LAST		FIRST MIDDLE LAST		1702 Rutland Ave.	
Tom Love		Rebecca Yates			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		226-20-0336		Susie Jefferson 1702 Rutland Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART 1. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <u>Respiratory Failure</u>					
4360 DUE TO, OR AS A CONSEQUENCE OF					
(b) <u>Aspiration Pneumonia</u>					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
<u>Cerebrovascular Accident, Seizures</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>October 25, 1981</u> to <u>January 30, 1982</u> , that <u>xx</u> (we) last saw the deceased alive on <u>January 30, 1982</u> , and that in <u>xx</u> (our) opinion death occurred on the date and hour and from the causes stated above <u>xx</u> (we) (did <u>xx</u> (not)) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
<u>Katherine Mealy M.D.</u>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		1/30/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Katherine Mealy, M.D.		c/o Maryland General Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		2/4/82		Baltimore Cem.	
23d. LOCATION (CITY OR TOWN)		COUNTY		STATE	
Baltimore				MD	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR	
Wm. C. March F/H		1101 E. North Ave.		FEB 1 1982	
				25b. REGISTRAR'S SIGNATURE	
				<u>James J. Kithen</u>	

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FEB 1 1985

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 0 1 0 7 5			
1 - FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
CARROLL E. HOLLAND				1 - 23 82 10:15 AM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
M.		NEGRO		10 24 09		72 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Md.		U.S.A.				BALTO. CITY MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BALTO.		1500 BLOCK N. EDEN ST		CUSTODIAN		School	
13a. STATE				13b. COUNTY		13c. CITY OR TOWN	
Md						BALTO.	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
George HOLLAND				LEILA JILES			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO				215-09-5682		CLARA F. HOLLAND 1509 N. EDEN ST	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) Acute myocardial infarction							
4100 DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerotic coronary artery disease							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)							
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 minutes							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
Diabetes mellitus (adult onset)							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
None						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
				HOUR A.M. MONTH DAY YEAR			
				P.M. 19			
21d. INJURY OCCURRED				21e. PLACE OF INJURY		21f. LOCATION	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1978, 1982, to 1982, 1982, that (I) (we) last saw the deceased alive on 1/26/82, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
James D. Carr				M.D.		1/25/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
JAMES D. CARR				1427 Madison Ave - 21217			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
BURIAL		1/26/82		CEDAR Hill Cem.		A.A. COUNTY MD	
24. FUNERAL DIRECTOR				25a. DATE RECORDED (REGISTRAR)			
Locks FUNERAL HOME 1304 N. Central Ave				JAN 26 1982			
NAME				REGISTRAR'S SIGNATURE			
				James J. Nathan			

Handwritten notes and diagrams on graph paper. The notes are mostly illegible due to fading. A large, faint circular diagram is visible in the center, possibly representing a celestial body or a technical drawing. The text is written in a cursive, handwritten style.

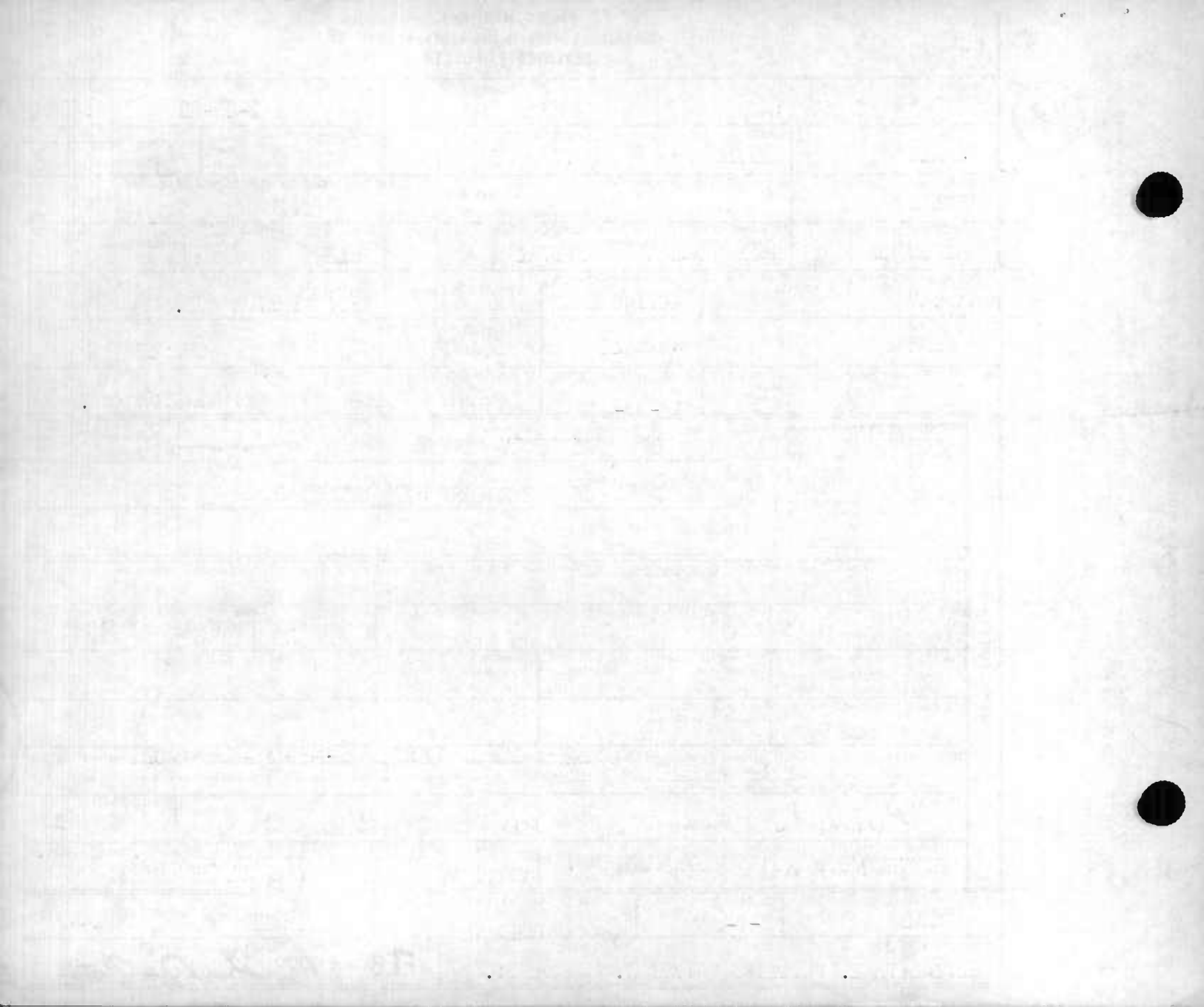
Handwritten notes at the bottom of the page, including the word "Time" and other illegible text.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 1 0 7 6	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) OCTAVIA HOLLEY					2a. DATE OF DEATH MONTH DAY YEAR 1-28-82			2b. HOUR 3:43AM			
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 11 29 13		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH CITY, GIVE STREET ADDRESS) CHURCH HOME AND HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLERK		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND					13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME MIDDLE GEORGE MARSHALL					15. MOTHER'S MAIDEN NAME MIDDLE JOANNA CHESLEY						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-24-6035		17. INFORMANT DENNIS HOLLEY			ADDRESS 521 WINSTON AVE.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO RESPIRATORY ARREST</b> 1749 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DO TO, OR AS A CONSEQUENCE OF (b) <b>CARCINOMA OF THE BREAST WITH SECONDARIES</b> DO TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <del>1-1-12</del> 1-28-82, to 1-28-82, that (I) (we) last saw the deceased alive on 1-28-82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED 1-28-82	
22b. SIGNATURE Purushothaman				DEGREE MD				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) XXXXXX PC, AV PURUSHOTHAMAN, MD.				22e. ADDRESS CHURCH HOSPITAL CORP. 100 N. BROADWAY BALTIMORE, MARYLAND 21231							
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 2-1-82		23c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND		24. FUNERAL DIRECTOR NAME ELIZABETH L. PHILLIPS 1721 N. MONROE ST.			
25a. DATE REC'D. BY REGISTRAR FEB 4 1982				25b. REGISTRAR'S SIGNATURE Thane Jan...							





Items #10a-22a Film G565 3/3/82 STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

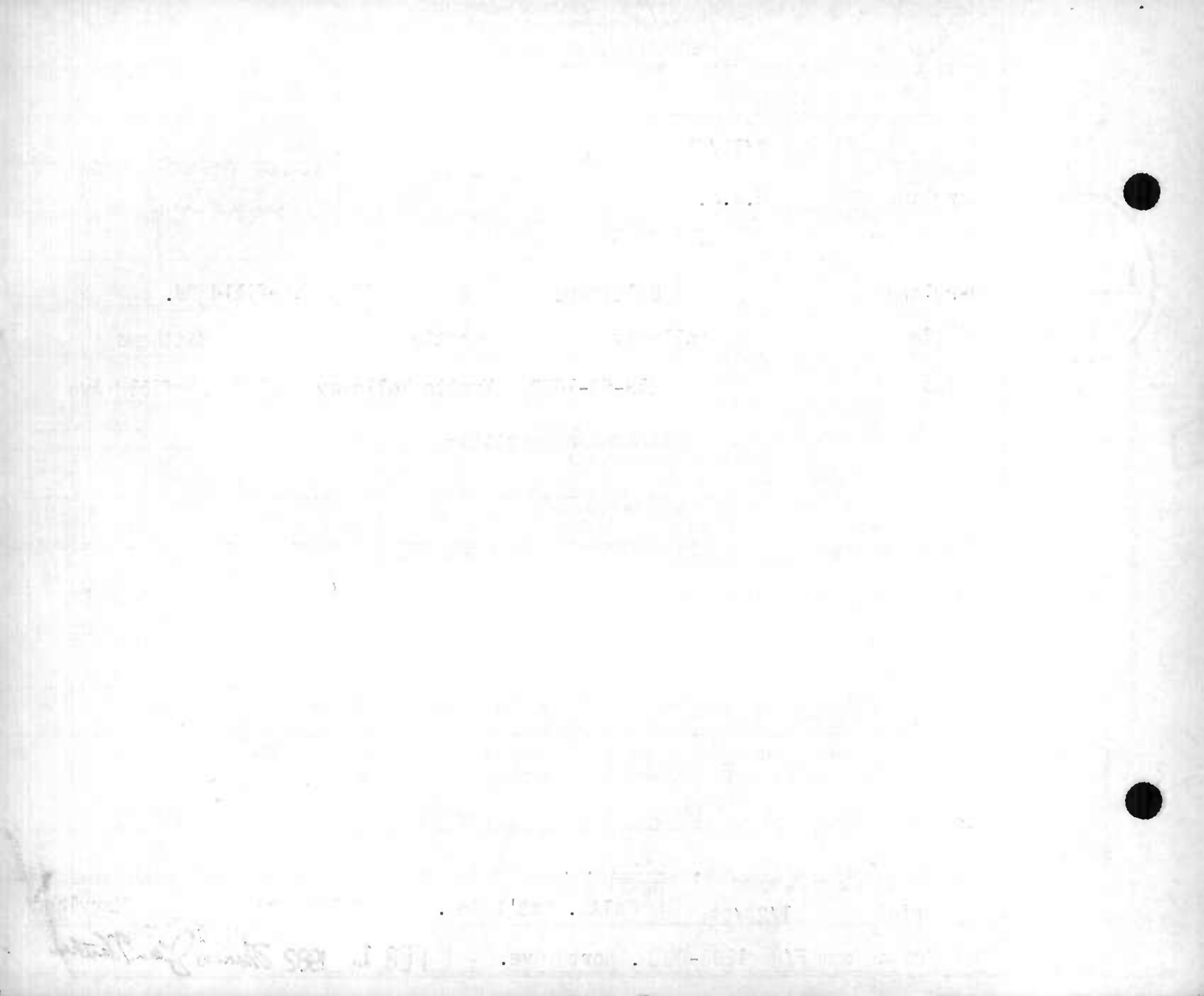
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		ESTIMATED		MONTH		DAY		YEAR		2b. HOUR	
Clarence		W		Holloway				1		23		19		82				M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR	
male	black	9/11/51		30 YRS.						1		24		19		82		5:10	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH										PM	
Maryland		U.S.A.		WIDOWED		DIVORCED		Baltimore City										MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY													
Baltimore		4303 Wakefield Road																	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS											
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4303 Wakefield Rd.											
14. FATHER'S NAME		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		MIDDLE		LAST									
Willie		Holloway				Mattie		Matthews											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		(YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
Yes				213-54-1473		Yvette Holloway		4303 Wakefield Ave											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		3049		Intravenous Narcotism		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
				(b)															
				(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?															
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>															
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
		HOUR A.M. MONTH DAY YEAR																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION															
22a. I certify that I took charge of the remains described above, held on		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion		death resulted from:		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE		Virginia L. Dolan		TITLE (SPECIFY)		M.D. Assistant		MEDICAL EXAMINER		DATE SIGNED		1/25/82							
EXAMINER'S NAME (TYPE OR PRINT)		Virginia L. Dolan, M.D.		ADDRESS		111 Penn Street, Baltimore, MD 21201													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY											
Burial		1/29/82		Balto. Nat'l Cem.		Baltimore		Maryland											
24. FUNERAL DIRECTOR		NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
Wm C Brown Comm F/H		1206-08 W. North Ave.				FEB 1 1982		Charles Jan Nathan											

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M 2/80



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
JAMES		HOLSEY						1		20		19		82		8:26	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
male	negro	8 6 12		69 YRS.						1		20		19		82	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
GA		USA				Baltimore City											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Baltimore		319 E. 21st St.															
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
MD				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		319 E. 21st. St.									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
No		256-10-7222		Henry Cooper		125 S. Culver St.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: 4392 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) _____ (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?													
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held on		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion															
death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED													
Ann M. Dixon, M.D.		M.D. Assistant		1-21-82													
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS															
Ann M. Dixon, M.D.		111 Penn St.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE											
Burial		1/29/82		Md. Veteran Cem.		Crownsville MD											
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
Wm. C. March F/H		1101 E. North Ave.		JAN 26 1982		James J. Nathan											

BP

1204 DHMH-17  
(VR A15 ME (1))  
15M 2/80



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
BUENA F. HOPSON			1-3-82			10:55AM		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
Female	White	May 19, 1911	70 YRS.			IF UNDER 24 HRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH					
Texas	USA		Baltimore City MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore	Sinai Hospital		Psychologist			Balto. City		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. CITY OR TOWN			13c. INSIDE CITY LIMITS?		
Maryland			Baltimore			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13d. STREET ADDRESS		
Sylvester B. Hopson			Nettie McMahon			1312 Bolton Street		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
No			572 24 4543			Mrs. Enid H. Sheppard, Ga.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. b) METASTATIC CARCINOMA DUE TO, OR AS A CONSEQUENCE OF c) DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
12-22-81			CA COLON			YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 12-16 1981, to 1-3 1982, that (I) (we) lost the deceased on 1-3-82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE CHARLES SCHWARTZ, MD						22c. DATE SIGNED 1-3-82		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS		
CHARLES SCHWARTZ, MD						SINAI HOSP.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Cremation			1/4/82		Green Mount		Balto., Md.	
24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons co.						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
4905 York Road Balto., Md. 21212						JAN 4 1982		James J. Nathan



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE														
1. FOR STATE REGISTRAR					8 2 0 1 0 8 0									
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH									
MADALYN E HOSHAL					1-18-82 6:30A.M.									
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR						
F		W		1-28-03		79 YRS.		MONTHS DAYS HOURS MIN						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH								
VIRGINIA		USA				BALTIMORE CITY MD.								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH PLACE, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY						
BALTIMORE		MONTIBELLO STATE Hosp				Registrar		YMCA						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS						
MD		-		BALTO		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		West 1008 E. 38 STREET.						
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME									
JOHN EPPS					SHAWNEE Nettie Shields									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES					16b. SOCIAL SECURITY NO.					17. INFORMANT ADDRESS				
No					214-03-3047					Mrs. James Woodward Lorton, Va. 22079				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY:														
IMMEDIATE CAUSE (a) 4960 CARDIO RESPIRATORY ARREST														
DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC OBSTRUCTIVE LUNG DISEASE										15 mts.				
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
ASCVD; CHF; H/O LATENT SYPHILIS														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
				HOUR A.M. MONTH DAY YEAR										
21d. INJURY OCCURRED				21e. PLACE OF INJURY				21f. LOCATION						
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 5/25/81 to 1/18/82, that (I) (we) last saw the deceased alive on 1/17/82, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
23. SIGNATURE										DEGREE		23c. DATE SIGNED		
Syed Mohsin Ali Hassan MD										ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		1/18/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS				
SYED MOHSIN ALI HASSAN										90 MONTIBELLO ST. HOSP.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION				
Removal				K/K 1/19/82						CITY OR TOWN COUNTY STATE				
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR						25b. REGISTRAR'S SIGNATURE		
Anatomy Board						Balto., Md.								



1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100
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UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

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BUREAU OF PLANT INDUSTRY  
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UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 1 0 8 1			
1. FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
MARIE		K.		HOUGHTON				1		11	82	11:10A	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Female		White		5 12 1895		86		MONTHS		DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
BALTIMORE		USA				BALTIMORE City						MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
BALTIMORE		CATON MANOR NUR. CENTER		Housekeeper		Helene's Estate							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
MD.		Baltimore		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21228					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
George Scheihing		Emma R. Filbey											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
No		219-308967		L. Lura		Caton Manor							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF Atherosclerosis CVD (c) DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)									
		HOUR A.M. MONTH DAY YEAR											
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION									
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (the hospital) attended the deceased from 12/23/82, 1982, to 1/11, 1982, that (I) (we) last saw the deceased alive on 1/11, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did) (did not) view the body after death.													
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED							
Herbert J. Levickas MD		MD				1/12/82							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
Herbert J. Levickas MD		5404 East Drive										(21227)	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION							
Burial		1-14-82		Loudon Park Cemetery		Baltimore		COUNTY		STATE		MD.	
24. FUNERAL DIRECTOR		NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Charles L. Stevens Funeral Home, Inc.		1501 E. Fort A				JAN 19 1982		Charles L. Stevens					

15-58701-NA

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 7 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. HOUR		
FIRST MIDDLE LAST Susan Harwood Houstle			MONTH DAY YEAR XX 1 8 19 82			M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD	2d. HOUR	
female	white	MONTH DAY YEAR Jan. 29, 1945	36 YRS.	MONTHS DAYS HOURS MIN.		1 10 19 82	3:00 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
NEBRASKA		USA				Baltimore City MD.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Baltimore		1806 South Road/ Garage				OFFICE CLERK		HOSPITAL
13a. STATE			13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS		
MD.				BALTIMORE	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	1806 SOUTH ROAD		
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
ARCH HOUSTLE				ALICE CLAUTICE				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
NO			224-68-0185		ARCH HOUSTLE 1806 SOUTH ROAD 21209			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Acute carbon monoxide intoxication</u> 9520 DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.								
(b) _____ DUE TO, OR AS A CONSEQUENCE OF								
(c) _____								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY?
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
			? P.m. est. 1/8 1982		inhaled automobile fumes			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
			garage		1806 South Road, Baltimore City, MD			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE			TITLE (SPECIFY)			DATE SIGNED		
<i>Thomas D. Smith</i>			M.D. Deputy Chief			1/11/82		
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS					
Thomas D. Smith, M.D.			111 Penn Street, Baltimore, MD 21201					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
BURIAL		JAN. 13, 1982		NEW CATHEDRAL CEM.		BALTIMORE MD.		
24. FUNERAL DIRECTOR NAME ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
MITCHELL-WIEDEFELD HOME 6500 YORK RD. 21212				JAN 10 1982		<i>Thomas D. Smith</i>		

RECEIVED

NOV 19 1964



RECEIVED

RECEIVED



NOV 19 1964

NOV 19 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 0 1 0 8 3	
1 - FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>LEONARD DONALD HOWARD</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JANUARY 10, 1982</b>		2b. HOUR <b>9:15 pm</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Mar. 31, 1923</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>58</b> YRS IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Church Home &amp; Hosp.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Roofer</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Roofing</b>	
13a. STATE <b>Md.</b>		13b. CITY OR TOWN <b>Anne Arundel Pasadena</b>	13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Unknown</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Loretta Howard</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW 2 216-12-6501</b>		17. INFORMANT ADDRESS <b>John Heinz- 13 St. Agnes Rd. Glen Burnie, Md. 21061</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ANOXIC BRAIN DAMAGE</b> <b>3481</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>RESPIRATORY ARREST</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>11-14</b> , 19 <b>81</b> , to <b>1-10</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>1-10</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (he) (she) (it) did not view the body after death, so state.)					
22b. SIGNATURE <b>Paul E. Gormley</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>1/10/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>PAUL E. GORMLEY MD</b>		22e. ADDRESS <b>CHURCH HOME CORP. 100 NORTH BROADWAY BALTIMORE, MD: 21231</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/14/1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Mem. Park</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Glen Burnie, Anne Arundel Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 12 1982</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Mc Cully F. H. Mountain &amp; Tick Neck Rds. 21122</b>		25b. REGISTRAR'S SIGNATURE <b>Thomas J. Harrison</b>			

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 2 0 1 0 8 4	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Melvin Howard						2a. DATE OF DEATH KNOWN <input type="checkbox"/> ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1 12 1982		2b. HOUR M 6:10 a. M.			
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 1 12 1972		6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. 72		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1 13 1982		2d. HOUR a. M.	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.	
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1102 Druid Hill Avenue, Apt. 1206				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md				13b. COUNTY		13c. CITY OR TOWN BALTO		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1102 DRUID HILL AVE	
14. FATHER'S NAME FIRST MIDDLE LAST William Howard						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie Reid					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) —		17. INFORMANT Myrtle Lewis		ADDRESS 1821 Riggs Ave			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Virginia L. Dolan M.D.						TITLE (SPECIFY) Assistant MEDICAL EXAMINER		DATE SIGNED 1-14-82			
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.						ADDRESS 111 Penn Street					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 1/14/82		23c. NAME OF CEMETERY OR CREMATORY MT ZION CEM		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO			
24. FUNERAL DIRECTOR NAME Vernon R. Bailey						ADDRESS 1348 N. Calhoun St		25a. DATE REC'D. BY REGISTRAR JAN 18 1982		25b. REGISTRAR'S SIGNATURE Thomas J. [Signature]	

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DHMH-17  
(VR A15 ME (5))  
15M 2/80



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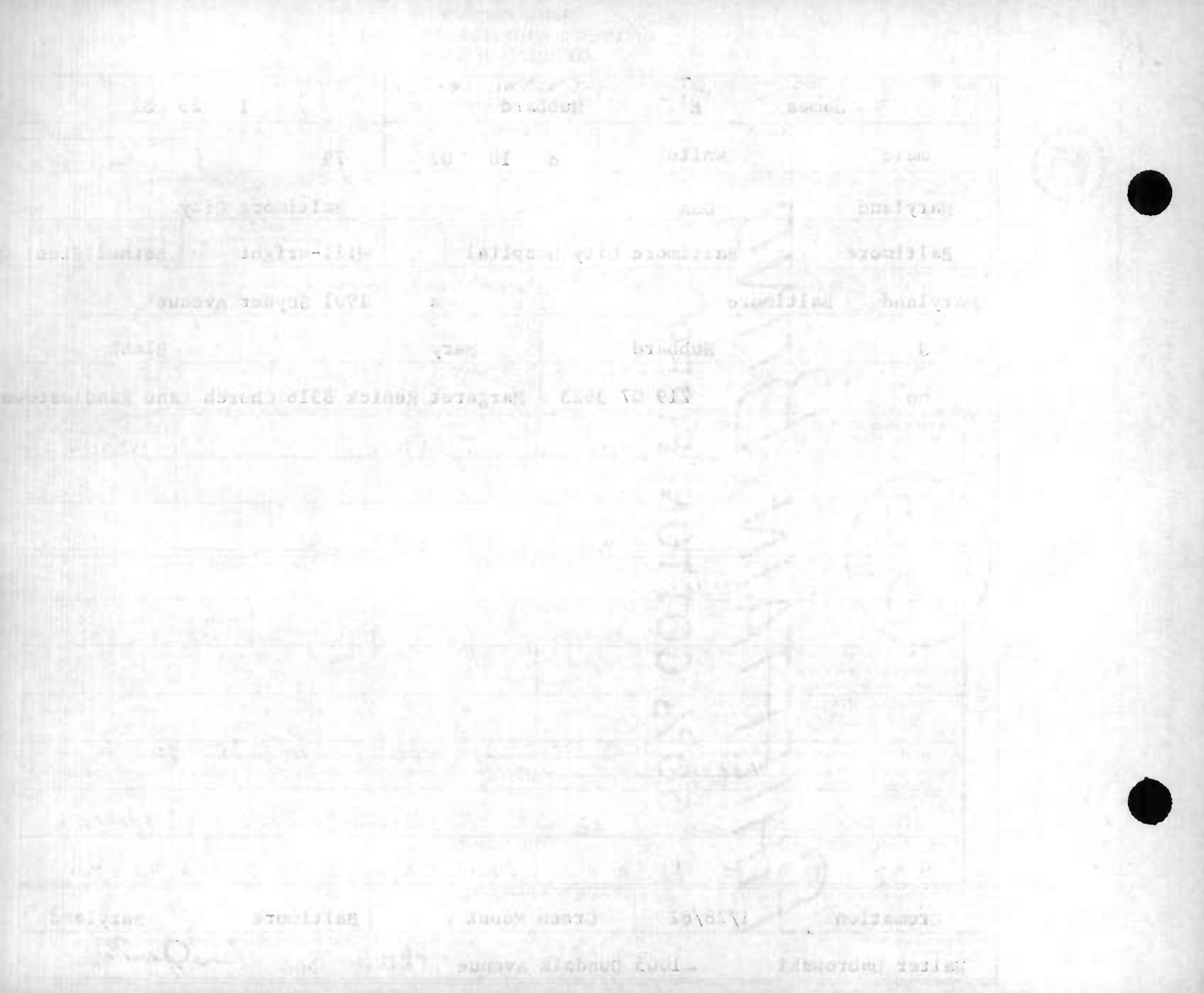
1571

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 2 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 1 0 8 5			
1. FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
James		E		Hubbard				1		26	82		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
male		white		MONTH 8 DAY 10 YEAR 02		79		MONTHS		DAYS			
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland		USA				Baltimore City							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Baltimore		Baltimore City Hospital		Millwright		Bethel Steel C							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Maryland		Baltimore				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1901 Snyder Avenue					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
J		Mary											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
no		219 07 3623		Margaret Renick		8516 Church Lane Randlestown							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY:										M. NOTES			
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION										15 years			
DUE TO, OR AS A CONSEQUENCE OF (b) HYPERTENSION										10 years			
DUE TO, OR AS A CONSEQUENCE OF (c) ATRIAL FIBRILLATION													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
CA. OF LUNG													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
		HOUR A.M. MONTH DAY YEAR											
		P.M. 19											
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION									
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from OCT 21, 19 46, to DEC 28, 19 81, that (I) (we) last saw the deceased alive on 12/28/81, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED							
MAX BAUM, MD						1/28/82							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
		7422 EASTERN AVE. BALTO-MD											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY		STATE			
Cremation		1/28/82		Green Mount		Baltimore		Maryland					
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
NAME		ADDRESS											
Walter Dabrowski		1005 Dundalk Avenue		FEB 9 1982									



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires: that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 2 0 1 0 8 6			
1. DECEASED NAME (TYPE OR PRINT) Louis Byron Hubbard				2a. DATE OF DEATH MONTH DAY YEAR January 8, 1982			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 29, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mass.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY, MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance		12b. KIND OF BUSINESS OR INDUSTRY Co. Schools	
13a. STATE Maryland		13b. COUNTY A.A.		13c. CITY OR TOWN Severn		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Unknown		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown		16. STREET ADDRESS 8002 Quarterfield Road			
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		17b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17c. INFORMANT (Wife) ADDRESS Mrs. Myrtle M. Hubbard		17d. Same as # 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> 4280 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Chronic Obstructive Pulmonary Disease, Renal Failure</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>12-25</u> , 19 <u>81</u> , to <u>1-8</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>1-8</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Lawrence A. Zeidman</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1-8-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Zeidman				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12 Jan. 82		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk		23d. LOCATION CITY OR TOWN COUNTY STATE Elkridge, Howard, MD.	
24. FUNERAL DIRECTOR SINGLETON FUNERAL HOME		25. DATE REC'D. BY REGISTRAR JAN 12 1982		26. REGISTRAR'S SIGNATURE <u>James J. Van Nuthen</u>			

8-11-54

LOUIS B. HUBBARD



COPIES FILED



James Earl Ray

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 1 0 8 7	
FOR film 6565/ 3-10-82 jdr 1- STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RUTH NAOMI HUBBE			2a. DATE OF DEATH MONTH DAY YEAR JANUARY 3, 1982		2b. HOUR 5:45a <sup>M</sup>
3 SEX Female	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR Nov. 20, 1934	6. AGE (IN YEARS LAST BIRTHDAY) 47 YRS		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto., Md.	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10 CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Hospital, Inc.		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland			13b. COUNTY Balto.	13c. CITY OR TOWN Baldwin	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Richard DeShield			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 218.74.8780	17 INFORMANT ADDRESS Henry E. Hubbe (Husband) Same as 13e		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u> <u>1629</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>LUNG CANCER 3 MONTHS</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) December 31		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 100 - N. BROADWAY 21231 Baltimore Maryland	
22a. I certify that (I) (this hospital) attended the deceased from <u>OCTOBER 31</u> , 19 <u>81</u> , to <u>JANUARY 3</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>JANUARY 3</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not see the deceased before death.)					
22b. SIGNATURE <i>Walter Bender</i>		DEGREE M.D.		22c. DATE SIGNED 1/3/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WALTER BENDER MD		22e. ADDRESS CHURCH HOSPITAL CORPORATION 100 - N. BROADWAY 21231			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 1/6/1982	23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24 FUNERAL DIRECTOR NAME Walter Brooks Bradley Inc., Dundalk Md 21222		25a. DATE REC'D. BY REGISTRAR JAN 6 1982			
		25b. REGISTRAR'S SIGNATURE <i>James Van Natten</i>			



(M)

ALL INFORMATION CONTAINED  
HEREIN IS UNCLASSIFIED  
DATE 01-10-2001 BY 10412

(S)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	2	0	1	0	8	8	
1- FOR STATE REGISTRAR										CERTIFICATE OF DEATH							
1. DECEASED NAME (TYPE OR PRINT)										2a. DATE OF DEATH							
EMMA LOUISE HUBER										JAN - 15-82 9:08 AM							
3 SEX			4 RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
FEMALE			WHITE			MAY 4 1910			71 YRS.			MONTHS		DAYS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH								
Maryland			USA						BALTIMORE CITY MD.								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
BALTIMORE			S.B.G.H.							Home maker			Own Home				
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS					
MD			A.A.			Glen Burnie			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			214 BENNIERE RD					
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME												
AUGUST SUESSE					NELLIE UNKNOWN												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR DATES)					17. INFORMANT							
No					None					HENRY H. HUBER, JR. ST. PATE, PA.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))																	
PART I. DEATH WAS CAUSED BY																	
IMMEDIATE CAUSE (a) Acute renal failure, cardiac arrest																	
DUE TO, OR AS A CONSEQUENCE OF (b) Septic, Respiratory failure																	
DUE TO, OR AS A CONSEQUENCE OF (c) S/P Whipple Procedure																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Chronic Renal Failure																	
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
11/12/81					elective					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
					HOUR A.M. MONTH DAY YEAR												
					P.M. 19												
21d. INJURY OCCURRED					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION							
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>										STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 11/7/81, to 1/15/82, that (I) (we) lost saw the deceased alive on 1/15/82, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE										DEGREE			22c. DATE SIGNED				
[Signature]										MD			1/15/82				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS							
BADRE										S.B.G.H.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)					23b. DATE			23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION				
Burial					Jan. 18, 82			Cedar Hill Cem.					Brooklyn Park AA Md.				
24. FUNERAL DIRECTOR										25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
H. B. Burnie										JAN 18 1982			James J. Nathan				
Singleton Funeral Home, Glen Burnie, Md.																	

BP

EMMA LUCAS HUBER

1870-1871

1871

1871-1872

1872-1873

1873-1874

1874-1875

1875-1876

1876-1877

1877-1878

1878-1879

1879-1880

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 0 8 9

REG. NO

1. DECEASED NAME (TYPE OR PRINT) <b>EMMA</b>		MIDDLE <b>Lillian</b>		LAST <b>HUDGINS</b>		26. DATE OF DEATH <b>JANUARY</b>		MONTH <b>21</b>		YEAR <b>82</b>		28. HOUR <b>9:50A</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>8</b> DAY <b>13</b> YEAR <b>21</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>60</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS HOURS <b></b> MIN. <b></b>					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Baltimore, Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.									
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>JOHNS HOPKINS HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>							
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Dundalk</b>												13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>6906 Norman Avenue 21222</b>	
14. FATHER'S NAME FIRST <b>John</b> MIDDLE <b>C.</b> LAST <b>Mooney</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Laura</b> MIDDLE <b>V.</b> LAST <b>Mc Donald</b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>220-07-9350</b>		17. INFORMANT <b>Carson J. Hudgins</b>		ADDRESS <b>6906 Norman Ave, 21222</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest 1/21 930</b> <b>1919</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Brain Tumor (Astrocytoma)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (c) <b></b>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>930</b> <b>HA</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
19a. DATE OF OPERATION <b>12/30/81</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Astrocytoma</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. <b></b> MONTH <b></b> DAY <b></b> YEAR <b>19</b> P.M. <b></b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b></b>											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b></b>		21f. LOCATION STREET <b></b> CITY OR TOWN <b></b> COUNTY <b></b> STATE <b></b>											
22a. I certify that (I) (this hospital) attended the deceased from <b>1/4/82</b> 19 <b>82</b> to <b>Jan 21</b> 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>Jan 21</b> 19 <b>82</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED <b>1/21/82</b>			
22b. SIGNATURE <b>Noel Tulipan</b> DEGREE <b></b>						ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Noel Tulipan</b>						22e. ADDRESS <b>Johns Hopkins</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1-25-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Eastwood, Balto. Co. Md.</b> COUNTY <b></b> STATE <b></b>									
24. FUNERAL DIRECTOR NAME <b>C.S. Zeiler &amp; Son Inc.</b> ADDRESS <b>6224 Eastern Avenue</b>						25. DATE REC'D. BY REGISTRAR <b>JAN 22 1982</b> REGISTRAR'S SIGNATURE <b>Thom...</b>									

1 54 FEB PPT 8

1 54 FEB PPT 8



Handwritten notes at the bottom left, including "JAN 28 1954" and other illegible markings.

Items #18a-22a Film G564 2/3/82 re STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 2 0 1 0 9 0

1. FOR STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST  
Walter Hughes

2a. DATE KNOWN OF DEATH MONTH DAY YEAR  
XX 1 6 1982

2b. HOUR M  
M

3. SEX Male

4. RACE Black

5. DATE OF BIRTH MONTH DAY YEAR  
1 10 10 71

6. AGE (IN YEARS LAST BIRTHDAY) YRS.  
71

IF UNDER 1 YR. MONTHS DAYS HOURS MIN.  
IF UNDER 24 HRS.

7c. DATE PRONOUNCED DEAD MONTH DAY YEAR  
1 6 1982

7d. HOUR M  
11:45 A. M

7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  
MD

7b. CITIZEN OF WHAT COUNTRY?  
USA

8. MARRIED ☐ NEVER MARRIED ☐  
WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH  
Baltimore City, MD.

10. CITY OR TOWN OF DEATH  
Baltimore

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  
1735 Moreland Avenue

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  
retired

12b. KIND OF BUSINESS OR INDUSTRY

13a. STATE  
MD

13b. COUNTY

13c. CITY OR TOWN  
Baltimore

13d. INSIDE CITY LIMITS? YES ☐ NO ☐

13e. STREET ADDRESS  
1735 Moreland Ave

14. FATHER'S NAME FIRST MIDDLE LAST  
John Hughes

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  
Laura Young

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  
no no

17. SOCIAL SECURITY NO.  
215-22-6123

17. INFORMATION ADDRESS  
Baltimore 1735 Moreland Ave

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I DEATH WAS CAUSED BY:  
4292 IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular disease  
DUE TO, OR AS A CONSEQUENCE OF  
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:  
(b) DUE TO, OR AS A CONSEQUENCE OF  
(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED WHILE ☐ NOT WHILE ☐ AT WORK ☐ AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.

TITLE (SPECIFY)  
M.D. Assistant MEDICAL EXAMINER

ACTUAL SIGNATURE Virginia L. Dolan DATE SIGNED 1-6-82

EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D. ADDRESS 111 Penn Street

23a. BURIAL, CREMATION, REMOVAL

23b. DATE  
1 9, 82

23c. NAME OF CEMETERY OR CREMATORY  
Mt Zion Cemetery

23d. LOCATION CITY OR TOWN COUNTY STATE  
Baltimore MD

24. FUNERAL DIRECTOR NAME ADDRESS  
Blithen L. Miller 3207 W. Northwood

25. DATE REC'D. BY REGISTRAR  
JAN 8 1982

25b. REGISTRAR'S SIGNATURE  
Frances Van Nether

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1883



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 0 1 0 9 1			
FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>ELLEN HYLE</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>JAN 12 1982</b>		2b. HOUR <b>M</b>	
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>FEB 19 91</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>90</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>ENGLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTO</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>22 MALLOW HILL RD</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>DOMESTIC</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD.</b>		13b. COUNTY		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>MICHAEL O'NEILL</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARYANN FLEMING</b>		13e. STREET ADDRESS <b>22 MALLOW HILL RD</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>213-32-1837</b>		17. INFORMANT ADDRESS <b>HELEN TIPTON 22 MALLOW HILL RD</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4140</b> IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASHD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>years</b>				PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>1/12</b> , 19 <b>82</b> , to <b>1/12</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>1/12</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>James Nolan</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1/12/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>J J NOLAN</b>		22e. ADDRESS <b>1 Mallow Hill Ave Balt 21229</b>					
23a. BURIAL, CREMATION, REMOVAL SPECIES <b>BURIAL</b>		23b. DATE <b>1/15/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LOUDEN PARK</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO MD</b>	
24. FUNERAL DIRECTOR NAME <b>WEIDER FUNERAL HOME</b>		ADDRESS <b>EDMONDSON AVE</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 19 1982</b>		25b. REGISTRAR'S SIGNATURE <b>James Nolan</b>	

RECEIVED  
JAN 19 1955

NEW YORK, N.Y.

TO THE DIRECTOR, FBI

FROM THE SAC, NEW YORK

SUBJECT: [illegible]

RE: [illegible]

DATE: [illegible]

BY: [illegible]

FOR THE DIRECTOR, FBI

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

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Item 8 g564 2/17/82 gj

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

8 2

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1- FOR  
STATE  
REGISTRAR

## CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ROBERT E. HYLOCK</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JANUARY 28, 1982</b>		2b. HOUR <b>4:34A M</b>						
3. SEX <b>Male</b>		4. RACE <b>Cauc.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1/21/43</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>39</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS <b>39</b>		8. IF UNDER 24 HRS HOURS MIN. <b>39</b>	
9a. BIRTHPLACE (STATE OR FOREIGN) <b>Balto., Md.</b>		9b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY MD.</b>					
10. CITY OR TOWN OF DEATH <b>Balto.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>JOHNS HOPKINS HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Salesman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Potato Chip Co.</b>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN <b>Md. Balto. Balto.</b>						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>800 N. Linwood Ave. 21205</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Andrew H. Hylock</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Florence (nee Jett) Hylock</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>no</b>		16b. SOCIAL SECURITY NO. <b>217-40-5145</b>		17. INFORMANT ADDRESS <b>Florence Hylock, 124 Kinship Rd. 21222</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b> <b>4254</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>congestive heart failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cardiomyopathy</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>45 min</b> <b>2 months</b> <b>2 months</b>										PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>sepsis, alcohol</b>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER).		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>1/25</b> , 19 <b>82</b> , to <b>1/28</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>1/28</b> , 19 <b>82</b> , and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Steven P. Schuman</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>1/28/82</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Steven P. Schuman</b>				22e. ADDRESS <b>601 W Broadway East</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2/1/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>					
24. FUNERAL HOME <b>St. Anne's Funeral Home, Inc.</b> <b>3331 Brehms Lane, Balto., Md. 21213</b>				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>JAN 29 1982</b> <b>James J. Kather</b>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the Registrar within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 1 0 9 3			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>DAISY INGRAM</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>1 8 82</b>		2b. HOUR <b>1:15 A.M.</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>NEGRO</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2 10 24</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS <b>57</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>USA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City MD</b>	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>South Balto. Gen. Hosp.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>AI MARK</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Technical</b>	
13a. STATE <b>Md.</b>				13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Balto.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Ed Smith</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Bessie.</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>4299</b>		17. INFORMANT ADDRESS <b>Raymond L. Ellis 3834 The Ahameda</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO-pulmonary collapse</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Steven W. Eaton MD</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1/8/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>STEVEN W. EATON</b>		22e. ADDRESS <b>3001 S. HANOVER ST. BALTIMORE, MD</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/12/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cem</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Leroy O. Dyett, F.H.</b>		ADDRESS <b>4600 Lib. Hgth.</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 11 1982</b>		25b. REGISTRAR'S SIGNATURE <b>Thomas J. [Signature]</b>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
8 2 0 1 0 9 4 CERTIFICATE OF DEATH									
FOR 1. STATE REGISTRAR									
REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>EDMUND F. IWANTSCH</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>11/7/82</b>		2b. HOUR <b>11:04 PM</b>	
3. SEX <b>MALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 6 1906</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.		7. UNDER 1 YEAR MONTHS DAYS <b>11 04</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>AUSTRIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNION MEMORIAL HOSPITAL</b>				12a. USUAL OCCUPATION (IF NO WORK FOR MOST OF WORKING LIFE) <b>CABINET MAKER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>MD.</b>		13b. COUNTY <b>-</b>		13c. CITY OR TOWN <b>BALTO.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>FRANC IWANTSCH</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>KATHERINE PEISCHL</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>216-03-4370</b>		17. INFORMANT ADDRESS <b>HERMINE IWANTSCH (WIFE) SAME ADDRESS</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the colon. C metastasis</b> <b>1539</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>37</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>2/30</b> , 19 <b>81</b> , to <b>1/7</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>1/7</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Alan Kimmel</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>1/7/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Alan Kimmel</b>				22e. ADDRESS <b>201 E University Pkwy</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>1/11/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. Md.</b>			
24. FUNERAL HOME NAME ADDRESS <b>Schmonek Funeral Home, Inc. 3331 Brehms Lane, Balto. Md. 21213</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 12 1982</b>		25b. REGISTRAR'S SIGNATURE <b>Thane J. [Signature]</b>			



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SIGNATURE \_\_\_\_\_

JANUARY 1968, VOL. 1, NO. 1

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>BLUPPIS JACKSON</b>			2a. DATE OF DEATH MONTH <b>1</b> DAY <b>16</b> YEAR <b>82</b>			2b. HOUR <b>12:45<sup>AM</sup></b>			
3. SEX <b>male</b>		4. RACE <b>col</b>		5. DATE OF BIRTH MONTH <b>Sept</b> DAY <b>30</b> YEAR <b>1913</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS.		7. UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN) <b>Richmond Va.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City MD</b>			
10. CITY OR TOWN OF DEATH <b>Balt.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NO SUCH FACILITY, GIVE STREET ADDRESS) <b>Provident Hosp</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Labor</b>		12b. KIND OF BUSINESS OR INDUSTRY <b></b>	
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST <b>Charlie</b> MIDDLE <b></b> LAST <b>Jackson</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Elizabeth</b> MIDDLE <b></b> LAST <b>Picherson</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b></b>		17. INFORMANT ADDRESS <b>Mrs. Delia Jackson 1609 Riggs Ave</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory arrest</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute pulmonary edema</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>atherosclerotic Cardiovascular Disease</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>Chronic Obstructive pulmonary Disease</b>									18b. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION <b>1/15</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b></b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR <b></b> A.M. MONTH <b></b> DAY <b></b> YEAR <b>19</b> P.M.			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET <b></b> CITY OR TOWN <b></b> COUNTY <b></b> STATE <b></b>			
22a. I certify that (I) (this hospital) attended the deceased from <b>1/15</b> , 19 <b>82</b> , to <b>1/16</b> , 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>1/15</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>A. Pidlacan MD</b>						DEGREE <b>MD</b>		22c. DATE SIGNED <b>1/16/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>A. PIDLACAN MD.</b>						22e. ADDRESS <b>PROVIDENT HOSPITAL BALT. MD. 21215</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>1-22-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary Cem.</b>		23d. LOCATION CITY OR TOWN <b>Baltimore</b> COUNTY <b>AA</b> STATE <b>MD</b>		
24. FUNERAL DIRECTOR NAME <b>Joseph L. Russ</b> ADDRESS <b>2222 W. North Ave</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 18 1982</b>		25b. REGISTRAR'S SIGNATURE <b>James J. [Signature]</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Richard L. U.S.A.  
President 1901  
Labor  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 3 days with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 0 9 6

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Jessie Jackson			2a. DATE OF DEATH MONTH DAY YEAR 11/3/82		2b. HOUR 5:15 AM						
3. SEX F		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 4 17 02		6. AGE (IN YEARS LAST BIRTHDAY) 19 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH city					
10. CITY OR TOWN OF DEATH Baltimore City		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lutheran Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) none		12b. KIND OF BUSINESS OR INDUSTRY none			
13a. STATE Md.		13b. COUNTY Balto		13c. CITY OR TOWN Balto		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4023 Grantly Rd			
14. FATHER'S NAME FIRST MIDDLE LAST David Williams			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucinda								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			16b. SOCIAL SECURITY NO. 227404079			17. INFORMANT ADDRESS Gladys Jackson 4023 Grantly					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 2399 DUE TO, OR AS A CONSEQUENCE OF (b) Bacteria & pleuropneumonia DUE TO, OR AS A CONSEQUENCE OF (c) ? man -										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I (this hospital) attended the deceased from 12-23, 19 81, to 1/31, 19 82, that (I/we) last saw the deceased alive on 11/3/82, 19, and that in (my/our) opinion death occurred on the date and hour and from the causes stated above, (I/we) (did/did not) view the body after death.											
22b. SIGNATURE Sissus Anhe						DEGREE M			22c. DATE SIGNED 1/3/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Sissus Anhe						22e. ADDRESS Lutheran Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1/7/82			23c. NAME OF CEMETERY OR CREMATORY Family Lot			23d. LOCATION CITY OR TOWN COUNTY STATE Mecherri, Va.		
24. FUNERAL DIRECTOR NAME Leroy L. Dyett F.H.						ADDRESS 4600 High St.			25a. DATE REC'D. BY REGISTRAR JAN 4 1982		
						25b. REGISTRAR'S SIGNATURE Renee Jan Nester					





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 2 0 1 0 9 7	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) <b>Mamie Jackson</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>1/1/82</b>			2b. HOUR <b>3:30 A</b>		M	
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 14 1891</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>90</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Calvert</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>City (Balto)</b> MD.					
10. CITY OR TOWN OF DEATH <b>Balto.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3608 Edgewood Road</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Domestic</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Md.</b>			13b. COUNTY <b>City</b>		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3608 Edgewood Road</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>David Brooks</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Queenie Brooks</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>216-32-0555</b>		17. INFORMANT ADDRESS <b>Laura A. Gross 3608 Edgewood Rd. Balt. Md</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cocaine jtw bladder</b> <b>1889</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Shouane, coronary artery disease</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Marsha Brown</b>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					22c. DATE SIGNED <b>1/1/82</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>					23b. DATE <b>Jan. 7-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Brooks Chr. Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>St. Leonard Calvert Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Spencer E. Sewell</b>					ADDRESS <b>Box 31, Prince Frederick, Md</b>			25a. DATE REC'D. BY REGISTRAR <b>JAN 8 1982</b>		25b. REGISTRAR'S SIGNATURE <i>Theresa J. ...</i>	



Handwritten notes and text, mostly illegible due to blurriness and bleed-through. Visible fragments include:

- Top section: "Total", "Date", "Time", "Location", "Remarks".
- Middle section: "Total", "Date", "Time", "Location", "Remarks".
- Bottom section: "Total", "Date", "Time", "Location", "Remarks".

There are also some larger, more legible handwritten notes in the center and bottom of the page.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 0 1 0 9 8			
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
2. DECEASED NAME (TYPE OR PRINT)				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Ethel S. Jacobs				2a. DATE OF DEATH MONTH DAY YEAR 1-3-82			
3. SEX Female				2b. HOUR 1:17 PM			
4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 6 30 1891		6. AGE (IN YEARS LAST BIRTHDAY) 90		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (COUNTRY) MASS.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto City MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME	
13a. STATE Md.		13b. COUNTY BALTO.		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 3601 Fords Lane, Apt 418	
14. FATHER'S NAME FIRST MIDDLE LAST MORRIS SCHWARTZBERG		15. MOTHER'S MAIDEN NAME FIRST MIDDLE HATTIE BROWN		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			
16a. SOCIAL SECURITY NO. 217-26-6120		17. INFORMANT daughter. Mrs. Augusta Janofsky		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>perforated virus</u> 7998 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 113/ST 1-30pm 113/ST			
22a. I certify that (I) (this hospital) attended the deceased from 12 30 pm 19 11/3/81, to 1-30 pm 19 11/3/81, that (I) (we) last saw the deceased alive on above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Sally Person</u> DEGREE				22c. DATE SIGNED 1/3/82.		22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. MICKERSON	
22e. ADDRESS SINAI HOSPITAL				23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			
23b. DATE JAN. 5, 1982		23c. NAME OF CEMETERY OR CREMATORY DRUID RIDGE		23d. LOCATION PIKESVILLE BALTO. MD		24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215	
25a. DATE REC'D. BY REGISTRAR JAN 7 1982				25b. REGISTRAR'S SIGNATURE Dorcas Jean Weather			

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 0 9 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) John Martin Jacob			2a. DATE OF DEATH MONTH DAY YEAR January 13, 1982		2b. HOUR 4P M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR May 23, 1894	6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Long Green Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Co-Owner		12b. KIND OF BUSINESS OR INDUSTRY Kranz Music Company
13a. STATE Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN Timonium	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 211 Chantry Rd. 21093	
14. FATHER'S NAME FIRST MIDDLE LAST John George Jacob		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Margaret Heil			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 212-03-7112		17. INFORMANT ADDRESS Mrs. Irma Hoffman, same as #13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Respiratory failure</u> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerotic heart disease</u> 3 yr. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chromoclasiosis, generalized</u> 10 yr.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 da
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>3/30</u> 19 <u>76</u> to <u>1/13</u> 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>1/12</u> 19 <u>87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) saw the body after death.					
22b. SIGNATURE <u>Norman R. Freeman</u>		DEGREE M.D.		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Norman Freeman, M.D.		22e. ADDRESS 29 W. 29th Street			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-18-82		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland					
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc.		ADDRESS 1050 York Rd. Towson, Maryland		25a. DATE REC'D. BY REGISTRAR JAN 19 1982	
		25b. REGISTRAR'S SIGNATURE <u>Charles J. Whitson</u>			



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 1 0 0

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>JOSEPH. JAFFE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>01/08/1982</b>			2b. HOUR M <b>2:50 A</b>				
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>03/15/1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN) <b>RUSSIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>CITY</b> MD.				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>North Charles General</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Handycapper</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Horse Raising</b>		
13a. STATE <b>MD.</b>			13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3607 Chestnut Avenue</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Human Jaffe</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE <b>Fannie Adler</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				
16b. SOCIAL SECURITY NO. <b>030-20-6928</b>			16c. MARRIAGE NO. <b>21211</b>			16d. ADDRESS <b>3607 CHESTNUT AVE. BALTIMORE MD 21211</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>- UPPER GI BLEED AND</b> <b>1599</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>malignancy GI track</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>occult</b> Approximate interval between onset and death <b>DAYS</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>RENAL FAILURE</b>										
19a. DATE OF OPERATION <b>12/28/81</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>19</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>12/28/81</b> , 19 <b>81</b> , to <b>01/08/82</b> , 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>01/08/82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Dr. Anjarita</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>01/08/82</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ANJARITA</b>			22e. ADDRESS <b>NORTH CHARLES GEN HOSPITAL BALTIMORE MD 21218</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>JAN. 10, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ANSHE NEISEN</b>		23d. LOCATION <b>ROSEDALE BALTO. MD</b>			
24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS. INC.</b> ADDRESS <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 14 1982</b> 25b. REGISTRAR'S SIGNATURE <b>Francis J. Thayer</b>				

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

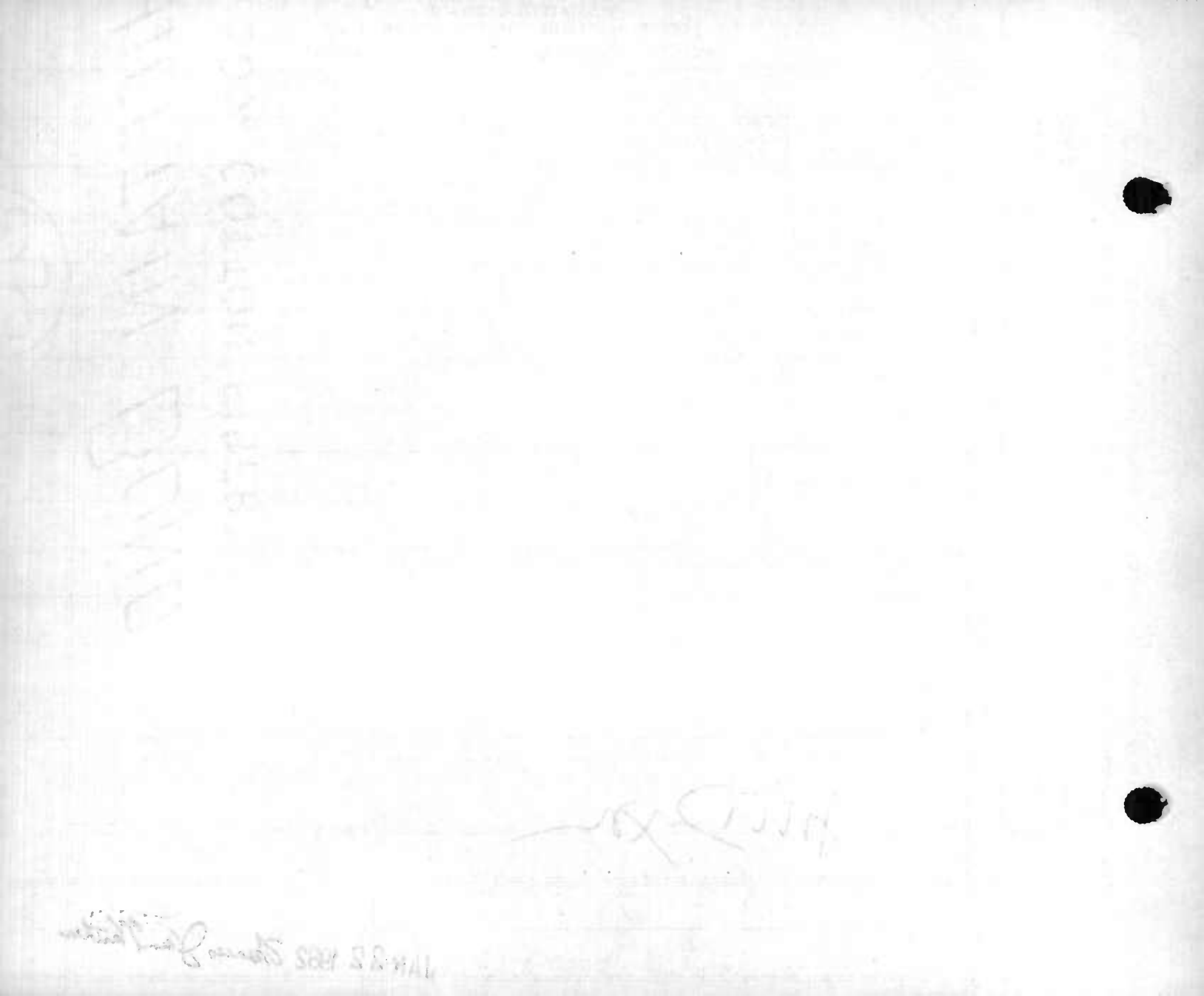
MEDICAL CERTIFICATION

out of [unclear] 5 SEP 41

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 2 0 1 1 0 1	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) <b>JOHN JAMES</b>										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR <b>1 21 19 82</b>	
3. SEX <b>male</b> 4. RACE <b>negro</b> 5. DATE OF BIRTH MONTH DAY YEAR <b>11 17 35 46</b> 6. AGE (IN YEARS) LAST BIRTHDAY YRS. <b>46</b> 7. MARried <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										2b. HOUR <b>2:52</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N.C.</b> 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b> 8. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>										2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>1 21 19 82</b>	
10. CITY OR TOWN OF DEATH <b>Baltimore</b> 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1906 E. 31st St.</b> 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)										12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Baltimore</b> 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS <b>1906 E. 31st. St.</b>											
14. FATHER'S NAME FIRST MIDDLE LAST <b>Myron James</b> 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rosa Parker</b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b> (IF YES, GIVE WAR OR DATES) 16b. SOCIAL SECURITY NO. <b>N/A</b> 17. INFORMANT ADDRESS <b>Rosa James 1906 E. 31st. St.</b>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Alcoholism</b> DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b> 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <b>Ann M. Dixon</b> TITLE (SPECIFY) <b>M.D. Assistant</b> MEDICAL EXAMINER DATE SIGNED <b>1-21-82</b>											
EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b> ADDRESS <b>111 Penn St.</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b> 23b. DATE <b>1/25/82</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Westview Mem. Pk.</b> 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Co. MD</b>											
24. FUNERAL DIRECTOR NAME ADDRESS <b>Wm. C. March F/H 1101 E. North Ave.</b> 25a. DATE REC'D. BY REGISTRAR <b>JAN 22 1982</b> 25b. REGISTRAR SIGNATURE <b>James J. Hester</b>											





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 4 and 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 1 0 2

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Johnnie Edward JAMES</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>January 14, 1982</b>		2b. HOUR <b>7:55a M</b>
3. SEX <b>male</b>	4. RACE <b>black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>5 10 1911</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Va</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Maryland General Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>MD</b>		13b. COUNTY	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>3841 Elmcroft Road</b>
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>223-26-8497</b>		17. INFORMANT ADDRESS <b>Margie James 3841 Elmcroft Road</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Endstage Kidneys with chronic renal failure and uremia</b> <b>4039</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>hypertension</b> DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>arteriosclerotic cardiovascular disease</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>October 31</b> , 19 <b>81</b> , to <b>January 14</b> , 19 <b>82</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>January 14</b> , 19 <b>82</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (not) view the body after death.					
22b. SIGNATURE <b>Huang-Ta Lin, M.D.</b> DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>1/14/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Huang- TA Lin, M.D.</b>				22e. ADDRESS <b>c/o Maryland General Hospital</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/18/82</b>	23c. NAME OF CEMETERY OR CREMATORY <b>King Mem Park</b>		23d. LOCATION CITY COUNTY STATE <b>Balto Co Md</b>
24. FUNERAL DIRECTOR <b>William C. March F/H 1101 E. North Ave</b>			25a. DATE REC'D. BY REGISTRAR <b>JAN 18 1982</b>		
			25b. REGISTRAR'S SIGNATURE <i>James J. [Signature]</i>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
CERTIFICATE OF DEATH									
REG. NO. 8 2 0 1 1 0 3									
1. DECEASED NAME (TYPE OR PRINT) <b>JAMES OSKER JANNEY</b>					2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR
					1		1		82
					4:54 a.m.				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
MALE		WHITE		MONTH DAY YEAR		65		MONTHS DAYS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
WEST VIRGINIA		U.S.A.				Baltimore City MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE		Lock Raven Veterans Med. Ctr.				Carpenter		Constr.	
13a. STATE					13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?
MARYLAND					A. A.		GLEN BURNIE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
FIRST MIDDLE LAST					FIRST MIDDLE LAST				
Millard Osker Janney					Lula Belle Griggs				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
YES					WWII		227 12 2395 Virginia Shipley 4227 Jim Bowers Rd.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>UPPER GI BLEED IN STOMACH AND DUODENUM</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(b) <u>DEEP LACERATIONS IN GE JYN AND CARDIAC OF STOMACH</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c) <u>SLIDING HIALIL HERNIA</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
			HOUR A.M. MONTH DAY YEAR						
			P.M. 19						
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION			
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK						CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>JANUARY 1, 19 82</u> , to <u>JANUARY 1, 19 82</u> , that <input checked="" type="checkbox"/> (we) lost									
saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated									
above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					DEGREE		22c. DATE SIGNED		
<u>Robert Fuld, MD</u>							1/1/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
ROBERT FULD, MD					LOCK RAVEN VETERANS MED CENTER				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		
Burial			1/4/1982		Meadowridge Cem.		Elkridge Howard Md.		
24. FUNERAL DIRECTOR					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
NAME Raymond C. Fink Glen Burnie, Md.					JAN 6 1982		<u>Thomas Van Nuthan</u>		

MEDICAL CERTIFICATION

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Items #18a-22a Film G565 3/5/82 re STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

1- STATE REGISTRAR

REG. NO. 8 2 0 1 1 0 4

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

1. DECEASED NAME (TYPE OR PRINT) <b>Earl Jefferson</b>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR <b>1 12 1982</b>			2b. HOUR <b>M 1:26</b>		
3. SEX <b>Male</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>12 20 61</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>20</b> YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>1 12 1982</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD.</b>		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore City Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Maryland</b>			13b. COUNTY	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>4727 Homesdale Avenue</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph Carroll</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Jefferson</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>218-78-1282</b>		17. INFORMANT ADDRESS <b>Mary Jefferson-same as above</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sickle Cell Disease with Complications</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that I took charge of the remains described above, held on death resulted from: <input checked="" type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion								
ACTUAL SIGNATURE <i>Thomas D. Smith</i>			TITLE (SPECIFY) <b>Deputy Chief</b>			DATE SIGNED <b>1/12/82</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>Thomas D. Smith, M.D.</b>			ADDRESS <b>111 Penn St. Balto., MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>1-16-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CedarHill Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. Md.</b>	
24. FUNERAL DIRECTOR NAME <b>CHAS. A. RICE FSPA</b>					ADDRESS <b>1300 Eutaw Pl.</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 18 1982</b>	
					25b. REGISTRAR'S SIGNATURE <i>Frances Van Natta</i>			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

*[Faint, mostly illegible text and markings covering the upper and middle portions of the page. Some words like "RECEIVED" and "OFFICE" are faintly visible.]*

*[Handwritten signature or initials in dark ink.]*

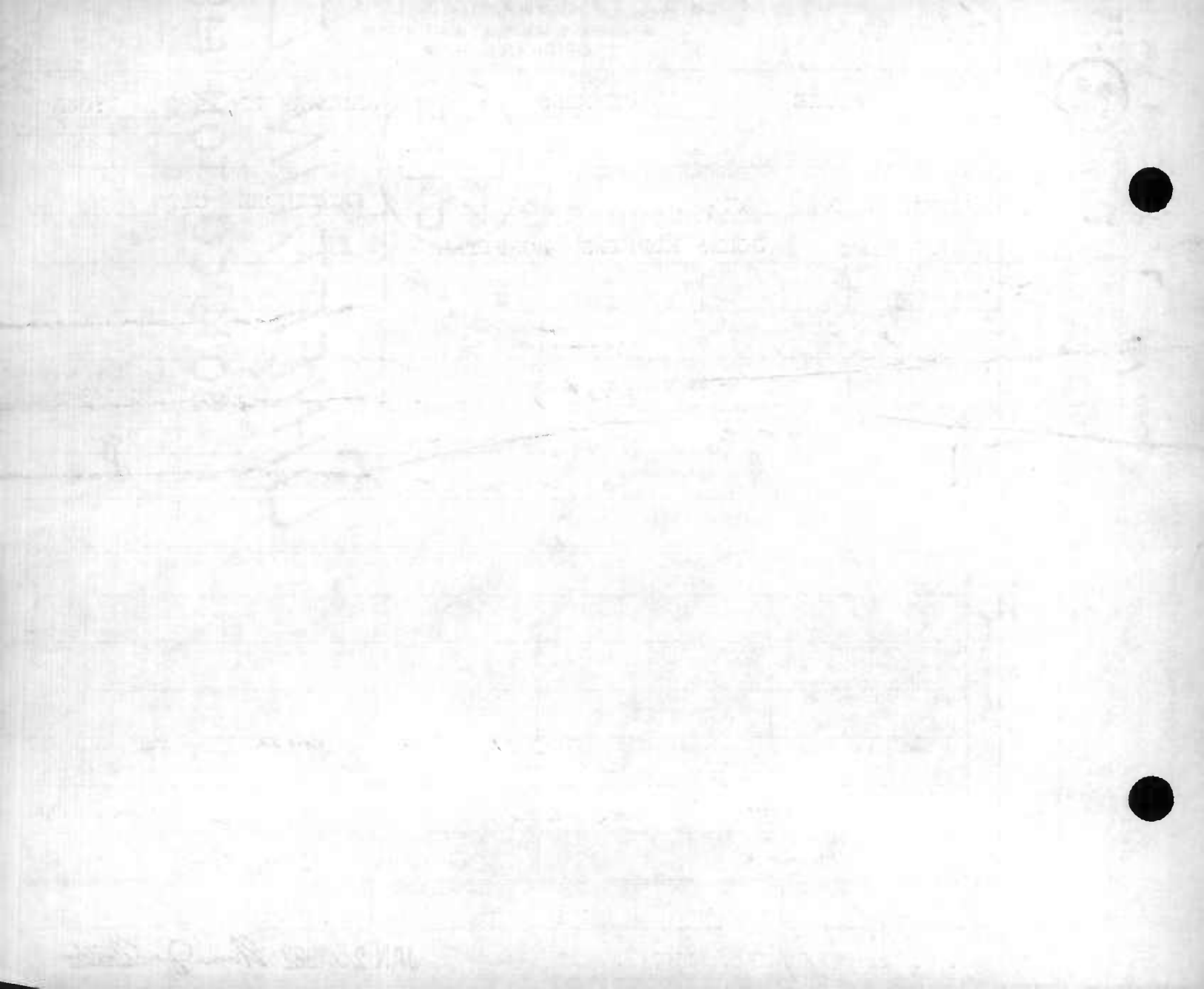


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. It should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 1 1 0 5	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) <b>HATTIE JENKINS</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>JANUARY 22, 1982</b>			2b. HOUR <b>1:04A M</b>		
3 SEX <b>Female</b>		4 RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 8 1982</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Farmville, VA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY MD.</b>					
10 CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>JOHNS HOPKINS HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? <b>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>		13e. STREET ADDRESS <b>1738 E. Lanvale Street</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Major Ellis</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Laura ?</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>223-16-1890</b>		17. INFORMANT ADDRESS <b>Evelyn C. Holmes 5427 Angora Terrace Phila. PA 19143</b>							
<b>X CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). <b>PART I. DEATH WAS CAUSED BY</b> IMMEDIATE CAUSE (a) <b>CAEDIO PORMONARY ARREST.</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>MYOCARDIAL INFARCTION.</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>20 mins</b> <b>16 hrs</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:10											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? <b>YES <input type="checkbox"/> NO <input type="checkbox"/></b>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <b>YES <input type="checkbox"/> NO <input type="checkbox"/></b>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>JAN 22</b> , 19 <b>82</b> , to <b>JAN 22</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>JAN 22</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Phelue</b>				DEGREE <b>MB CH. BSc</b>				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>JAN 22-82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MILNER</b>				22e. ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/25/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore MD</b>					
24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H, Inc.</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 25 1982</b>		25b. REGISTRAR'S SIGNATURE <b>James J. [Signature]</b>			

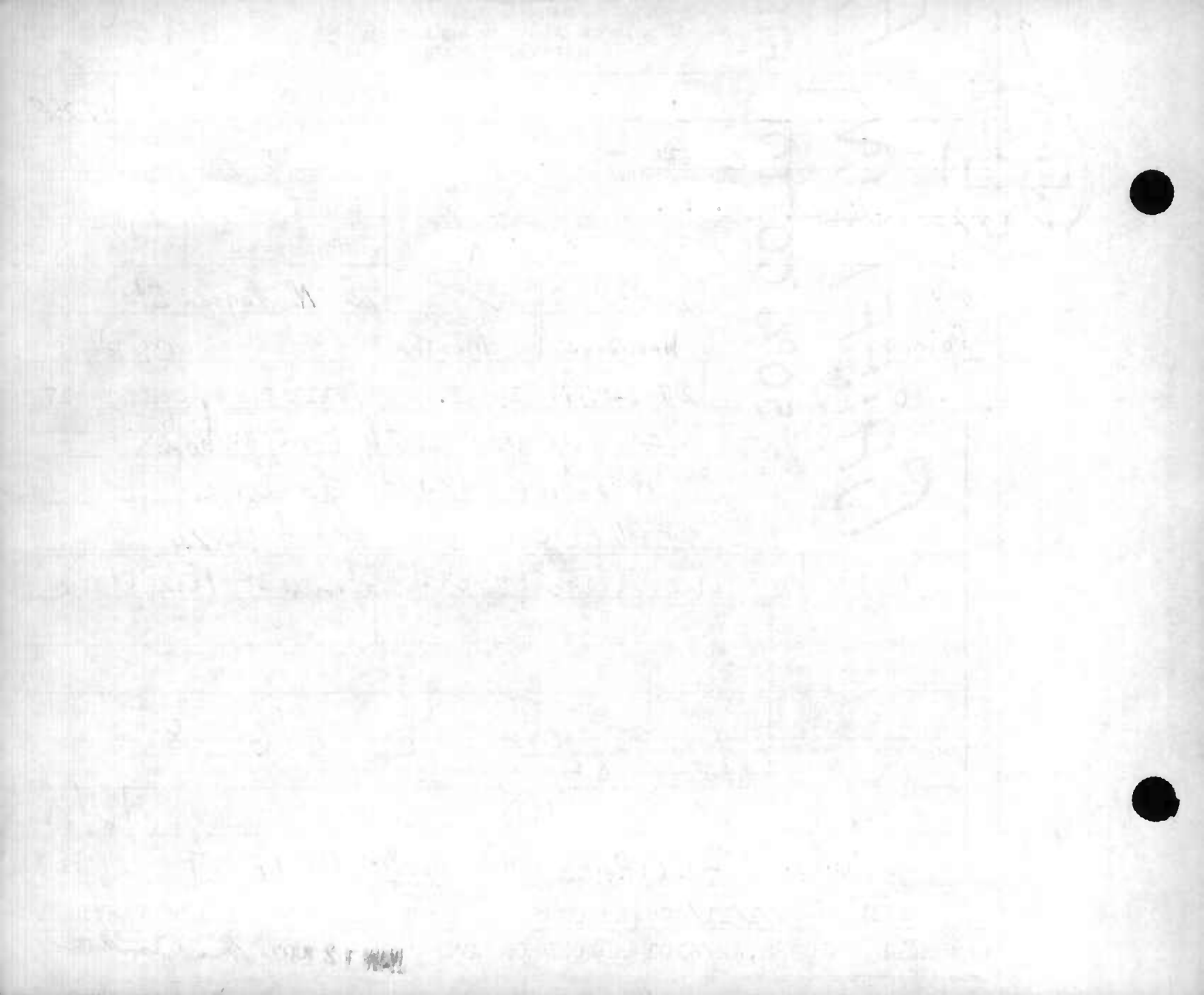


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT) <b>SUSIE B. JENKINS</b>				2a. DATE OF DEATH MONTH <b>JANUARY</b> DAY <b>6</b> YEAR <b>1982</b>		2b. HOUR <b>6:40 PM</b>		
3. SEX <b>FEMALE</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH MONTH <b>DEC.</b> DAY <b>16</b> YEAR <b>1896</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS HOURS <b></b> MIN. <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN) <b>NORTH CAROLINA</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BON SECOURS HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOMEMAKER</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b>			13b. COUNTY <b>BALTO.</b>		13c. CITY OR TOWN <b>BALTO.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>126 A. Payson St.</b>		
14. FATHER'S NAME FIRST <b>Prince</b> MIDDLE <b></b> LAST <b>Waegeve</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Martha</b> MIDDLE <b></b> LAST <b>Cloudy</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>219-22-9899</b>		17. INFORMANT ADDRESS <b>IDA B. WEBB/2111 BAKER STREET 17</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma with bone metastases</b> <b>1991</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Congestive Heart Failure</b> (c) <b>Atherosclerotic Heart Disease</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Diabetes mellitus; Gross Pericardium 20 Kernal stone</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				19c. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET <b>10/24</b> CITY OR TOWN <b>81</b> COUNTY <b>1/6</b> STATE <b>82</b>						
22a. I certify that (I) (this hospital) attended the deceased from <b>8/10/82</b> to <b>1/6/82</b> , that (I) (we) lost <b>1/6/82</b> view the deceased alive on <b>1/6/82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Juan A. Beltran</b>			22c. DATE SIGNED <b>1/6/82</b>			22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JUAN A. BELTRAN</b>					
22e. ADDRESS <b>1940 W. BALTIMORE ST 21223</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>01/11/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ARBUTUS MEM PARK</b>		23d. LOCATION CITY OR TOWN <b>ARBUTUS</b> COUNTY <b>BALTO</b> STATE <b>MARYLAND</b>				
24. FUNERAL DIRECTOR <b>MARSHALL W JONES, JR/4101</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 12 1982</b>		25b. REGISTRAR'S SIGNATURE <b>James J. [Signature]</b>			



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 1 0 7

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Mary Katherine Jennings</i>			2a. DATE OF DEATH MONTH DAY YEAR 1 3 82 9 15 AM		
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 8-13-1897	6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Maryland	13b. COUNTY -----	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 524 N. Chas St	
14. FATHER'S NAME FIRST MIDDLE LAST Patrick J. McMahon			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katherine Sice		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 213-52-9922	17. INFORMANT ADDRESS J.M. Jennings 5533 Todd Ave 21206		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARDIO PULMONARY ARREST</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>PULMONARY EDEMA</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>PNEUMONIA</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <i>MYOCARDIAL INFARCTION</i>			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>11/28</i> , 19 <i>81</i> , to <i>1/3/82</i> , 19 <i>82</i> , that (I) (we) last saw the deceased alive on <i>1/3</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>Larry Friedman</i>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>LARRY FRIEDMAN</i>		22e. ADDRESS <i>301 S CHAS ST</i>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE ✓	23c. NAME OF CEMETERY OR CREMATORY Baltimore National	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland
24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home		25. DATE REC'D. BY REGISTRAR JAN 7 1982	
6500 York Rd 21212			

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577-25-0855

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 22 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			ESTIMATED MONTH DAY YEAR			2b. HOUR		
Nellie Mae Jessa						XX 1 25 19 82						M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR				
female	white	11 13 11	70 YRS.			1 25 19 82				12:54	PM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
Virginia			U.S.A.						Baltimore City					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Baltimore			102 E Lafayette (rear)			Housewife								
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS		
Maryland						Baltimore			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			1723 St. Paul Street		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT		
Andrew			Magnolia			No			219-10-7514			7711 Old Battle Grove Road Evelyn E. Crawford-Balto., MD. 21222		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			PART I DEATH WAS CAUSED BY:			IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
4100			Thrombosis of left coronary artery with hemopericardium											
			(b)											
			(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .														
ACTUAL SIGNATURE			TITLE (SPECIFY)			DATE SIGNED								
Virginia L. Dolan			M.D. Assistant			1/25/82								
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS			111 Penn Street, Balto. MD 21201								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial			1/28/1982			Bel Air Mem. Gdns.			Bel Air Harford MD.					
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Duda-Ruck, Inc.			7922 Wise Avenue Dundalk, MD. 21222			JAN 29 1982			[Signature]					





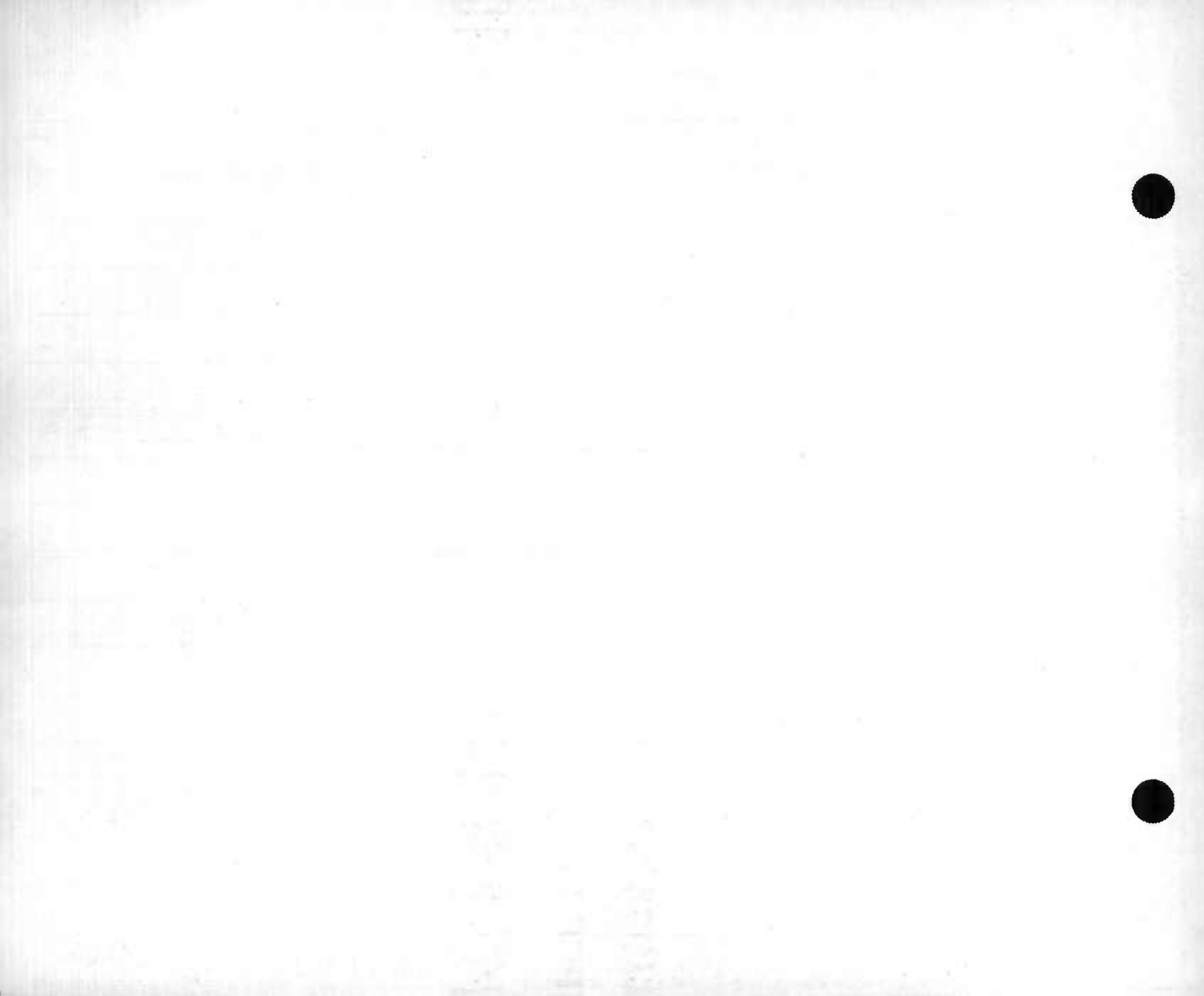
NEW YORK  
MAY 1891  
N.Y.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 2 0 1 1 0 9	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) Andrew Jeter						2a. DATE OF DEATH MONTH DAY YEAR January 7, 1982			2b. HOUR M		
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 12 18 93		6. AGE (IN YEARS LAST BIRTHDAY) 8.8 YRS.			7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SOUTH CAROLINA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2733 W. Fairmount Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13b. STREET ADDRESS 2733 W. Fairmount Ave.			
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN Baltimore							
14. FATHER'S NAME FIRST MIDDLE LAST STEPHEN JETER						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY GILLIAM					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 245-01-1137		17. INFORMANT ADDRESS MRS. LUCILVIA MURPHY 2733 W. FAIRMOUNT					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASCVD, COPD 4292 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Daliah Shamsuddin						DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 01/08/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DALIAH SHAMSUDDIN						22e. ADDRESS BON SECOURS HOSP					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 1/12/82		23c. NAME OF CEMETERY OR CREMATORY HARMONY MEM. PK.			23d. LOCATION CITY OR TOWN COUNTY STATE SEAT PLEASANT, MD.		
24. FUNERAL DIRECTOR NAME Wm. C. March F/H						ADDRESS 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR JAN 11 1982		25b. REGISTRAR'S SIGNATURE James J. Nathan	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 2 0 1 1 0	
1. FOR STATE REGISTRAR					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>HARRY E. JIGGETTS, Sr</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>1 27 82</b>			2b. HOUR <b>2:00 P.M.</b>			
3. SEX <b>MALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8 23 13</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>68</b>		IF UNDER 1 YEAR MONTHS DAYS <b>0 0</b>		IF UNDER 24 HRS. HOURS MIN. <b>0 0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>USA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>City</b> MD.					
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNIV. OF MARYLAND</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>					13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>CITY</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>RUBIN JIGGETTS</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>EVELYN JIGGETTS</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>					16b. SOCIAL SECURITY NO. <b>717-07-7565</b>		17. INFORMANT ADDRESS <b>Harry E. Jiggers Sr 2517 Pratt St</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SEPSIS</b> <b>2500</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>DIABETES + PHYSICAL CONDITION</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>POSITIVE STROKE</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>42 hr</b> <b>10 DAYS</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>0</b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>1/17</b> 19 <b>82</b> , to <b>1/27</b> 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>1/27</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>HACKEN M. STEIN</b>								DEGREE <b>MD</b>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)								22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>1-29-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto, Md</b>			
24. FUNERAL DIRECTOR NAME <b>Charles H. Powell</b>						24b. ADDRESS <b>319 M. Schroeder St</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 1 1982</b>		25b. REGISTRAR'S SIGNATURE <b>Thom. J. ...</b>	

Charles H. Powell & Sons, Jewelers

Bureau 1-24-82 Mt. Vernon

Box 140

MD

NOTION



Harriet E. Phipps 24-251 West 47

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 1 1 1 1 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) <b>MAJOR E. JIGGETTS</b>										2a. DATE OF DEATH MONTH DAY YEAR <b>01 23 82</b>				2b. HOUR <b>8:40<sup>PM</sup></b>	
3. SEX <b>M</b>		4. RACE <b>N</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>09 07 18</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>63</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>CITY</b> MD.									
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NCGH</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>FOREMAN</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>CANDY MAKER</b>							
13a. STATE <b>MD</b>				13b. COUNTY		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2304 LAURETTA AVE</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Major Jiggetts</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Emily Jones</b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>215-10-3307</b>		17. INFORMANT ADDRESS <b>Mabel M. Jiggetts 2304 Lauretta Ave.</b>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO RESPIATORY ARREST</b> <b>1850</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>MI</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>MI</b> DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>METASTATIC CA OF PROSTATE</b>															
19a. DATE OF OPERATION <b>1/22/82</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>METAST. CA OF PROSTATE</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from <b>1/17/82</b> , 19____, to <b>1/23/82</b> , 19____, that (I) (we) last saw the deceased alive on <b>1/23/82</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <b>Patel A</b>		DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>1/23/82</b>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS <b>NCGH</b>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/28/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cem.</b>		23d. LOCATION Baltimore COUNTY MD STATE									
24. FUNERAL DIRECTOR NAME ADDRESS <b>Wm. C. March F/H 1101 E. North Ave.</b>						25a. DATE REC'D BY REGISTRAR <b>JAN 25 1982</b>		25b. REGISTRAR'S SIGNATURE <b>Thomas J. March</b>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 1 1 2	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) <b>EARL JOHNSON</b>						2a. DATE OF DEATH MONTH <b>1</b> DAY <b>19</b> YEAR <b>82</b>		2b. HOUR <b>7:15</b> M <b>P</b>			
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH <b>6</b> DAY <b>18</b> YEAR <b>23</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>58</b> YRS		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS HOURS <b></b> MIN. <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Provident Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Truck Driver</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3809 Towanda Ave.</b>					
14. FATHER'S NAME FIRST <b>Williams</b> MIDDLE <b>Johnson</b> LAST <b></b>				15. MOTHER'S MAIDEN NAME FIRST <b>Lillian</b> MIDDLE <b>Johnson</b> LAST <b></b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW II</b>		17. INFORMANT ADDRESS <b>Margaret Johnson Same as above</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Insufficiency</b> <b>4860</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>Bilateral CVA</b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M.</b> <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>12/24/81</b> , 19 <b>81</b> , to <b>1/19/82</b> , 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>1/19/82</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Nigel E.R. Jackman M.D.</b>						DEGREE		22c. DATE SIGNED <b>1/19/82</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>NIGEL E.R. JACKMAN</b>						22e. ADDRESS <b>Provident Hosp. 2600 Liberty Highway</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>1/25/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Md. Veteran Cem.</b>		23d. LOCATION <b>Crownsville, Md.</b> STATE			
24. FUNERAL DIRECTOR NAME <b>A. RICE</b> FSPA <b>1300 E. H. PLACE</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 25 1982</b>		25b. REGISTRAR'S SIGNATURE <b>Thomas J. [Signature]</b>					

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• *Chlorophyll a* (Chl a) and *Chlorophyll b* (Chl b) are the primary photosynthetic pigments in green algae. They are responsible for capturing light energy and converting it into chemical energy through the process of photosynthesis. Chl a is the most abundant pigment, while Chl b is present in smaller amounts. Both pigments are found in the chloroplasts of green algae.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 2 0 1 1 1 3	
1. FOR STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EDNA S JOHNSON				2a. DATE OF DEATH MONTH DAY YEAR 01 16 82		2b. HOUR 7:46 PM		
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR 05 07 1893		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ca.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital of Baltimore						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3605 W. Belvedere Ave			
14. FATHER'S NAME FIRST MIDDLE LAST Earl Simms				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST — L Simms							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-12-6590		17. INFORMANT ADDRESS Mr. Lewis LYN 2816 E. Ellicott DR.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac arrest 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ASCVD (c) DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) hypothermia											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (a) (this hospital) attended the deceased from Jan 16 19 82, to Jan 16 19 82, that (a) (we) lost saw the deceased alive on Jan 16 19 82, and that in (a) (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Steven Grufferman MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 1/18/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Steven Grufferman MD				22e. ADDRESS Sinai Hospital of Baltimore, Md							
23a. BURIAL, CREMATION, REMOVAL (TYPE IF)		23b. DATE 1-25-82		23c. NAME OF CEMETERY OR CREMATORY Mt. Lion Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Lansdown Prince Georges					
24. FUNERAL DIRECTOR NAME Joseph J. Russ				ADDRESS 222 W. North Ave				25a. DATE REC'D BY REGISTRAR JAN 27 1982			



Handwritten text, possibly a signature or name, located in the middle section of the page.

Handwritten text at the bottom of the page, possibly a date or reference number.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR					8 2 0 1 1 4				
1. DECEASED NAME (TYPE OR PRINT) <b>HELEN White JOHNSON</b>					2a. DATE OF DEATH MONTH DAY YEAR 1 25 82				
3 SEX Female		4 RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 9 12 1902		6 AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		7b. HOUR 2 P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNION MEMORIAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Practical-Nurse</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>	
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>129 W. 29th Street Balto., Md. 21218</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>George White</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Hattie</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>212-14-9416</b>		17. INFORMANT <b>Baltimore</b> ADDRESS <b>Maryland 21216</b> <b>Mr. Cornelius Johnson 2214 Elsinore Ave</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Melanoma carcinoma</b> <b>1539</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>adenocarcinoma colon &amp; pulmonary mets.</b> DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>1/25/82</b> , 19____, to <b>1/25/82</b> , 19____, that (I) (we) lost saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>John H Epple</b> MD					DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John H Epple</b>					22e. ADDRESS <b>WMH</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/28/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Mem. Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore County, Maryland</b>			
24. FUNERAL DIRECTOR <b>BALTIMORE</b> <b>Herbert E Nutter Funeral Home</b>		NAME <b>BALTIMORE</b> ADDRESS <b>MARYLAND 21216</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 27 1982</b>		25b. REGISTRAR'S SIGNATURE <b>Thane Jan</b>			

JOHNSON

HELEN



BALTIMORE CITY

UNION NATIONAL HOSPITAL

BALTIMORE

11-14-41

RELEASED NON-MED DR. V. DOLAN PER MR. HENK

TO HOSPITAL OR ATTENDING PHYSICIAN: This requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 1 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>JUANITA JOHNSON</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JANUARY 26, 1982</b>			2b. HOUR <b>11:13PM</b>			
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5 28 53</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>28</b>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>JOHNS HOPKINS HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD</b>			13b. CITY OR TOWN <b>Baltimore</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>200 S. Ballou Ct.</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>- - -</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>- - -</b>			16. SOCIAL SECURITY NO. <b>N/A</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>			16b. SOCIAL SECURITY NO. <b>N/A</b>			17. INFORMANT ADDRESS <b>Novella Gardner 2212 E. Eager St.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ANOXIA</b> <b>3030</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Aspiration</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Esophageal VARICES - BLEEDING</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>20 min</b> <b>10 hours</b> <b>4 days</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <b>ETHANOL ABUSE x 20 YRS</b>									
19a. DATE OF OPERATION <b>1/26/82</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Bleeding Esophageal VAR.</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>1/23</b> 19 <b>82</b> to <b>1/26/82</b> 19 <b>82</b> , that (I) (we) lost saw the deceased alive on above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>John A. G. Simpson</b>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>1/26/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John A. G. Simpson</b>				22e. ADDRESS <b>Johns Hopkins Hosp</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2/1/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>King Mem. Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Co. MD</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Wm. C. March F/H 1101 E. North Ave.</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 28 1982</b>					
				25b. REGISTRAR'S SIGNATURE <b>Charles Sant Anthony</b>					



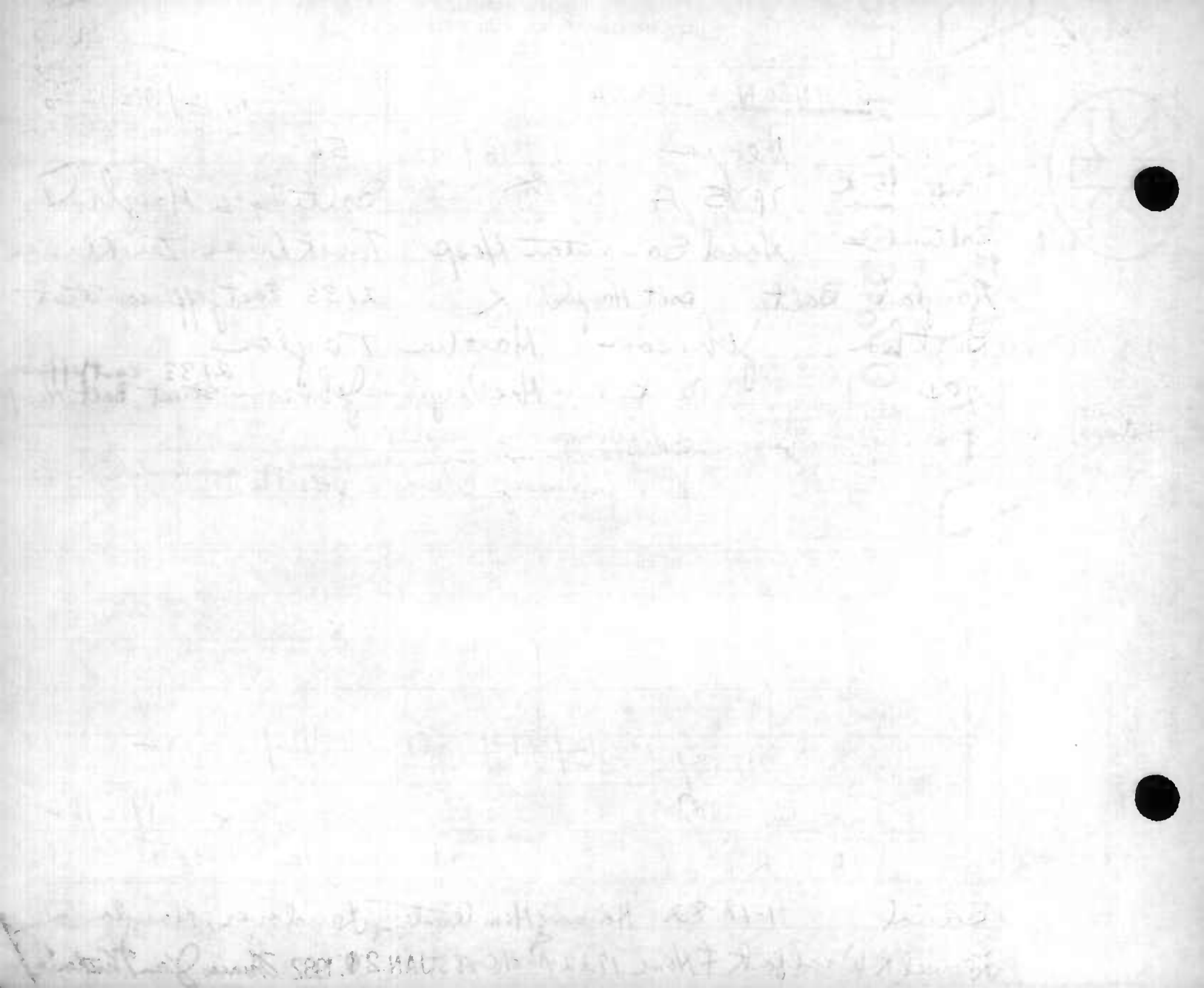


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8201116											
1. FOR STATE REGISTRAR						2a. DATE OF DEATH MONTH DAY YEAR 1/12/1982						2b. HOUR 12:55 P.M.									
1. DECEASED NAME (TYPE OR PRINT) <u>JOHNSON, LENZA</u>						3. SEX <u>MALE</u>						4. RACE <u>Negro</u>		5. DATE OF BIRTH MONTH DAY YEAR 7/16/1925		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS		7. IF UNDER 1 YEAR IF UNDER 24 HRS			
8. BIRTHPLACE <u>Walter Park Virginia</u>						9. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>						10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore, Maryland</u>							
10. CITY OR TOWN OF DEATH <u>Baltimore</u>						11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <u>Hood Samaritan Hosp</u>						12a. USUAL OCCUPATION (E OF WORK FOR MOST OF WORKING LIFE) <u>Truck Driver</u>						12b. KIND OF BUSINESS OR INDUSTRY <u>Truck Driver</u>			
13a. USUAL RESIDENCE (E NURSING HOME OR OTHER INSTITUTION) GIVE RESIDENCE BEFORE ADMISSION						13b. CITY OR TOWN <u>Balt. Maryland</u>						13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						13d. STREET ADDRESS <u>2133-East Jefferson Street</u>			
14. OTHER NAME <u>Bertha</u>						15. MOTHER'S MAIDEN NAME <u>Matha Taylor</u>						16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>yes</u>						16b. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Mrs Virginia Johnson</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CHF &amp; pulmonary edema - possible MI.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)						21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>						21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)						21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 12/21/1981 to 1/12/1982, that (I) (we) lost saw the deceased alive on 1/12/1982 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE <u>Inatuli mb</u> DEGREE				22c. DATE SIGNED 1/12/82							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>IVATOR I</u>						22e. ADDRESS <u>Hood Samaritan Hospital</u>															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>						23b. DATE 1-18-82						23c. NAME OF CEMETERY OR CREMATORY <u>Harmory Mem Cemetery</u>						23d. LOCATION CITY OR TOWN COUNTY <u>Landover, Maryland</u>			
24. FUNERAL DIRECTOR NAME <u>Samuel R. Woodfork F Home</u>						24b. ADDRESS <u>1722 North Capitol</u>						25a. DATE REC'D. BY REGISTRAR 20 JAN 20 1982						25b. REGISTRAR'S SIGNATURE <u>Theresa J. Thornton</u>			



1607 BP  
 DHMH - 16 50M / 181  
 (VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by page.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 0 1 1 7			
1 - FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Leslie V. Johnson</b>				20. DATE OF DEATH MONTH DAY YEAR <b>1-21-82</b>		2b. HOUR <b>M</b>	
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2-18-94</b> <b>JAN-10-94</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS <b>87</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Culpeper VA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3123 NORMOUNT AVE</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>at Home</b>	
13a. STATE <b>MD</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. STREET ADDRESS <b>3123 NORMOUNT AVE</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Gaskins</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rosie</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>2500</b>		17. INFORMANT ADDRESS <b>Johnny Harold 3123 Normount</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive CardioVascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Diabetes Mellitus</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 years</b> <b>Unknown</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>2-13</b> 19 <b>78</b> to <b>3-15</b> 19 <b>78</b> , that (I) <input checked="" type="radio"/> saw the deceased alive on <b>3-15</b> 19 <b>78</b> , and that in (my) <input checked="" type="radio"/> (our) opinion death occurred on the date and hour and from the causes stated above; (I) <input type="radio"/> (we) <input type="radio"/> (did) <input type="radio"/> (did not) view the body after death.							
22b. SIGNATURE <b>Samuel R. Owings, Jr. M.D.</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1-25-82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Samuel R. Owings, Jr.</b>				22e. ADDRESS <b>Constant Care Community Health Center 1501 DIVISION ST. Balto., Md. 21217</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/26/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt Auburn</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore MD</b>	
24. FUNERAL DIRECTOR NAME <b>Marjorie R. Harris</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 27 1982</b>		25b. REGISTRAR'S SIGNATURE <b>Thomas J. [Signature]</b>	

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*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]*

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 1 1 8

REG. NO.

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <i>LILLIAN W. JOHNSON</i>			2a DATE OF DEATH MONTH DAY YEAR <i>1/22/82</i>			2b HOUR <i>1:30 AM</i>			
3 SEX <i>FEMALE</i>		4 RACE <i>BLACK</i>		5 DATE OF BIRTH MONTH DAY YEAR <i>7 24 12</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>69</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN) <i>MARYLAND</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>BALTIMORE CITY</i> MD.			
10 CITY OR TOWN OF DEATH <i>BALTIMORE</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>BALTIMORE CITY HOSPITAL</i>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <i>MARYLAND</i>		13b. COUNTY <i>X.A.</i>		13c. CITY OR TOWN <i>ANNAPOLIS</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>1813 Bowman Drive</i>	
14 FATHER'S NAME FIRST MIDDLE LAST <i>DANIEL THOMAS</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>CARRIE JONES</i>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>				16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT ADDRESS <i>MERRIEL THOMAS 3203 Richmond Va. Detroit Ave.</i>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Arrest</i> <i>1419</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>CAROTID ARTERY OF THE TONGUE</i> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (1)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did not view the body after death.									
22b. SIGNATURE <i>Gordon Raphael</i>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>1/22/82</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>GORDON RAPHAEL</i>						22e. ADDRESS <i>BALTO CITY HOSPITALS</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>			23b. DATE <i>1-28-1982</i>		23c. NAME OF CEMETERY OR CREMATORY <i>PINELAWN MEM. PARK</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Annapolis A.A. Maryland</i>		
24. FUNERAL DIRECTOR NAME <i>WILLIAM REESE &amp; SONS MORTUARY, P.A.</i>						25a. DATE REC'D. BY REGISTRAR <i>JAN 28 1982</i>		25b. REGISTRAR'S SIGNATURE <i>James J. [Signature]</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



88 88 88



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH NO OTHER INFORMATION, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

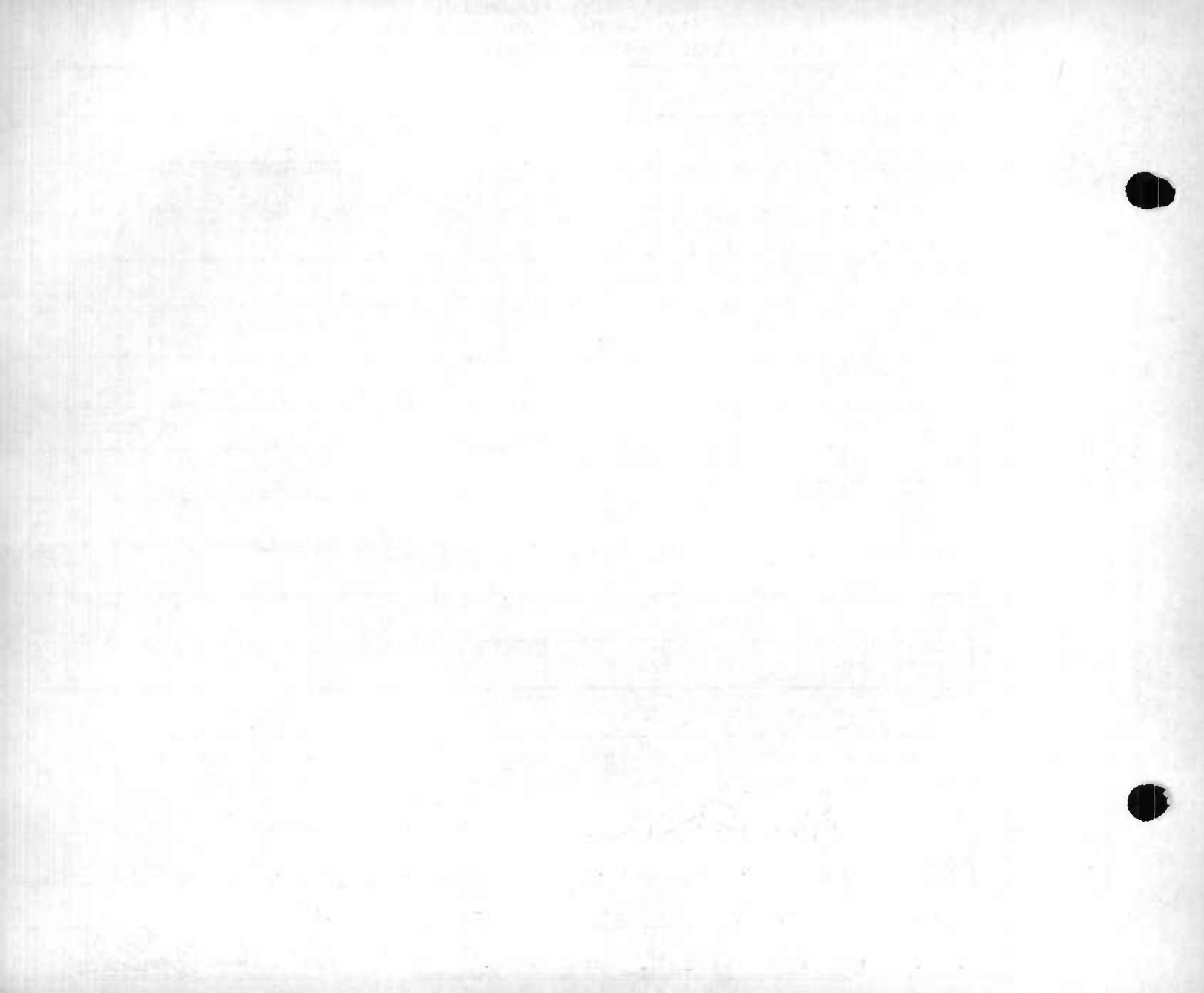
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR STATE REGISTRAR										2 0 1 1 1 9									
1. DECEASED NAME (TYPE OR PRINT) FIRST MABEL G. MIDDLE LAST JOHNSON										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 1 6 19 82 2b. HOUR M 10:55 P 55									
3. SEX female		4. RACE negro		5. DATE OF BIRTH MONTH DAY YEAR 10 6 29		6. AGE (IN YEARS) (LAST BIRTHDAY) 52 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1 6 19 82				2d. HOUR M 10:55 P 55			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD							
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE MD				13b. COUNTY				13c. CITY OR TOWN Baltimore				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 4209 Ethland Avenue			
14. FATHER'S NAME FIRST MIDDLE LAST Henry Battle										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lula Ebron									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 217-24-9396				17. INFORMANT ADDRESS Charles A. Johnson 4209 Ethland Ave											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER								DATE SIGNED 1-7-82							
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 1/12/82		23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD									
24. FUNERAL DIRECTOR NAME Wm. C. March F/H										ADDRESS 1101 E. North Ave.				25a. DATE REC'D. BY REGISTRAR JAN 8 1982		25b. REGISTRAR'S SIGNATURE			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This form may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 1 1 2 0 REG. NO.														
1. FOR STATE REGISTRAR																								
1. DECEASED NAME (TYPE OR PRINT)					FIRST MIDDLE LAST					2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR										
Madeline					Johnson					1/27/82				9:27P M										
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.														
Female		Black		9 MONTH 12 DAY 20 YEAR		61 YRS.		MONTHS DAYS		HOURS MIN.														
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH																		
MD		USA				Baltimore City MD																		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY										
BALTIMORE		GOOD SAMARITAN HOSPITAL																						
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13b. COUNTY					13c. CITY OR TOWN					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET ADDRESS				
MD					BALTO.										222 N. Carey Street.									
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME																			
FIRST MIDDLE LAST					FIRST MIDDLE LAST																			
WALTER					FREEMAN					MARXX MARY COOPER														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.					17. INFORMANT ADDRESS														
NO					216-18-6051					KENNETH JOHNSON 6851 Sturbridge Dr.														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
IMMEDIATE CAUSE (a) Cardio-pulmonary arrest																								
4100 DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial Infarct																								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost																								
DUE TO, OR AS A CONSEQUENCE OF (c) Cerebro-vascular accident																								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																								
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>												
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE																
22a. I certify that (this hospital) attended the deceased from 1/27/82, 19____, to 1/27/82, 19____, that (we) lost the deceased alive on 1/27/82, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) view the body after death.																								
22b. SIGNATURE				DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 1.28.82.												
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS																				
Aye Lwin				GOOD SAMARITAN HOSPITAL																				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE												
BURIAL				2/1/82				KING MEMORIAL				RANDALLTOWN MD												
24. FUNERAL DIRECTOR																								
W C MARCH F/H, INC. 1101 E. North Ave.																								
25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE																								
JAN 29 1982 [Signature]																								

100-100000

1/17/62

Johnson

Johnson

100-100000



100-100000  
1/17/62  
Johnson

100-100000  
1/17/62  
Johnson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body. **IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO. 8201121				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MARGARET S. JOHNSON</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>JANUARY 23, 1982</b>			2b. HOUR <b>11:55p</b>	
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 13 30</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>51</b>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>JOHNS HOPKINS HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3962 Wilsby Avenue</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Phillip Stokes</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Nannie Terry</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>214-24-7903</b>		17. INFORMANT ADDRESS <b>Nathaniel I. Johnson 3962 Wilsby Ave.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Pulmonary Edema</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Lung Cancer</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 min</b> <b>1 day</b> <b>6 months</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22. I certify that (I) (this hospital) attended the deceased alive on <b>1/23 11:50pm</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22a. SIGNATURE <b>DA FOLEY MD</b> DEGREE								22c. DATE SIGNED <b>1/24/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DA FOLEY MD</b>								22e. ADDRESS <b>Johns Hopkins Hospital</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>1/29/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore MD</b>		
24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H 1101 E. North Ave.</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 26 1982</b>		25b. REGISTRAR'S SIGNATURE <b>Frances Jan Nathan</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 1 1 2 2	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Martha B. Johnson</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>1 19 1982</b>			2b. HOUR <b>M</b>		
3. SEX <b>female</b>		4. RACE <b>black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1 8 03</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS <b>79</b>		IF UNDER 1 YEAR MONTHS DAYS <b></b>		IF UNDER 24 HRS. HOURS MIN. <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Va</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore city</b> MD.					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2334 W. Mosher Street</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b></b>			12b. KIND OF BUSINESS OR INDUSTRY <b></b>		
13a. STATE <b>Md</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2334 W. Mosher Street</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Peter Bright</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Maria Thrower</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>N/A</b>		17. INFORMANT ADDRESS <b>Harry Bright 2334 W. Mosher Street</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PARALYtic ARRYTHMIA</b> <b>4409</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ORGANIC HEART DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) <b>ATHEROSCLEROSIS</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b></b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b></b>											
19a. DATE OF OPERATION <b>N/A</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>N/A</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b></b>			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>N/A</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>N/A</b>						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> WHILE <input type="checkbox"/> AT HOME <input checked="" type="checkbox"/> (AT HOME, STREET, FARM, OFFICE, FARM, ETC.) <b>N/A</b>			21e. PLACE OF INJURY <b>N/A</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b></b>						
22. I certify that (I (this hospital) attended the deceased from <b>Dec 19 81</b> to <b>1982</b> , 19 <b></b> , that (I) (we) last saw the deceased alive on <b>Dec 19 81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22a. SIGNATURE DEGREE <b>Richard M. Hunt MD</b>										22b. DATE SIGNED <b>1-21-82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RICHARD M. Hunt MD</b>					22e. ADDRESS <b>2300 PARESON BLVD</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>1/25/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Md National Mem Pk</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Laurel</b>			
24. FUNERAL DIRECTOR NAME <b>William C. March F/H</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 22 1982</b>		25b. SIGNATURE <b>James J. Nathan</b>			





Handwritten text at the bottom left, possibly a signature or date, appearing to read "JAN 25 1905".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR STATE REGISTRAR

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST

1509 } DUE TO, OR AS A CONSEQUENCE OF

(b) CARCINOMA OF ESOPHAGUS

DUE TO, OR AS A CONSEQUENCE OF

(c) \_\_\_\_\_

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION 12-17-81

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED \_\_\_\_\_

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN STATIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 81

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE ☐ AT WORK ☐ NOT WHILE ☐ AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from DECEMBER 14, 1981 to JANUARY 15, 1982 that (I) (we) last saw the deceased alive on JANUARY 15, 1982 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.

22b. SIGNATURE M. L. BIJPURIA DEGREE MD

22c. DATE SIGNED 1-15-82

22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. L. BIJPURIA, M.D.

22e. ADDRESS CHURCH HOSPITAL CORPORATION  
100 N. BROADWAY, BALTIMORE, MD 21231

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

23b. DATE 1/21/82

23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem.

23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co. MD

24. FUNERAL DIRECTOR NAME Wm. C. March F/H ADDRESS 1101 E. North Ave.

25a. DATE RECEIVED BY REGISTRAR JAN 19 1982

25b. REGISTRAR'S SIGNATURE Thomas J. Smith

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	2	0	1	1	2	3
CERTIFICATE OF DEATH										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) FIRST <u>WILLIAM</u> MIDDLE <u>JOHNSON</u> LAST <u>JOHNSON</u> <u>WILLIAM JOHNSON</u>										2a. DATE OF DEATH MONTH DAY YEAR HOUR <u>1</u> <u>15</u> <u>82</u> <u>10:00A</u> <u>10:00 AM</u>						
3. SEX <u>Male</u>		4. RACE <u>Black</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>3</u> <u>15</u> <u>25</u>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <u>56</u> <u>15</u> <u>82</u>		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS. HOURS MIN.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>MD</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u> MD.										
10. CITY OR TOWN OF DEATH <u>Baltimore</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Church Home Hosp.</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY								
13a. STATE <u>MD</u>				13b. COUNTY		13c. CITY OR TOWN <u>Baltimore</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <u>1403 E. Baltimore St.</u>						
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES, NO OR UNKNOWN (IF YES, GIVE WAR OR DATES) <u>NO</u>				16b. SOCIAL SECURITY NO. <u>N/A</u>		17. INFORMANT ADDRESS <u>Thornton Dickinson 1403 E. Baltimore</u>										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																
PART I. DEATH WAS CAUSED BY:																
IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u>																
1509 } DUE TO, OR AS A CONSEQUENCE OF																
(b) <u>CARCINOMA OF ESOPHAGUS</u>																
DUE TO, OR AS A CONSEQUENCE OF																
(c) _____																
PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION <u>12-17-81</u>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN STATIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from <u>DECEMBER 14, 1981</u> to <u>JANUARY 15, 1982</u> that (I) (we) last saw the deceased alive on <u>JANUARY 15, 1982</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.																
22b. SIGNATURE <u>M. L. BIJPURIA</u> DEGREE <u>MD</u>				22c. DATE SIGNED <u>1-15-82</u>												
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>M. L. BIJPURIA, M.D.</u>				22e. ADDRESS <u>CHURCH HOSPITAL CORPORATION</u> <u>100 N. BROADWAY, BALTIMORE, MD 21231</u>												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				23b. DATE <u>1/21/82</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cem.</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Baltimore Co. MD</u>								
24. FUNERAL DIRECTOR NAME <u>Wm. C. March F/H</u>				ADDRESS <u>1101 E. North Ave.</u>				25a. DATE RECEIVED BY REGISTRAR <u>JAN 19 1982</u>								
								25b. REGISTRAR'S SIGNATURE <u>Thomas J. Smith</u>								

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 1 1 2 4					
1. FOR STATE REGISTRAR										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)					FIRST MIDDLE LAST <b>WILLIAM FLOYD JOLLY</b>					2a. DATE OF DEATH		MONTH DAY YEAR <b>1 11 82</b>		2b. HOUR <b>6:20 P.M.</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1 02 08</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VIRGINIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE</b> City MD.									
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>VAMC BALTIMORE, MARYLAND 21218</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>POSTAL CLERK</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>POSTAL SERVICE</b>					
13a. STATE <b>MARYLAND</b>						13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>ARBUTUS</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>4409 LEEDS AVENUE</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>WILLIAM F. JOLLY SR.</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARTHA UNKNOWN</b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO UNKNOWN) <b>YES</b>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WWII</b>		17. INFORMANT <b>LINDA BARR</b>		ADDRESS <b>4609 WILKENS AVENUE</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b> 5789 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Aspiration</b> (c) <b>GI hemorrhage / stress ulcer</b> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Metastatic Squamous Carcinoma of Lung</b>															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (this hospital) attended the deceased from <b>DECEMBER 4</b> , 19 <b>81</b> , to <b>JANUARY 11</b> , 19 <b>82</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased above <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.															
22b. SIGNATURE <b>Stephen R. Thom</b>				DEGREE <b>MO</b>				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1/11/82</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Stephen R. Thom</b>				22e. ADDRESS <b>Leah Roman U.A. Hosp.</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>				23b. DATE <b>01-14-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CROWNSVILLE VET. CEM.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>CROWNSVILLE A.A. MARYLAND</b>							
24. FUNERAL DIRECTOR NAME <b>HUBBARD FUNERAL HOME, INC.</b>				ADDRESS <b>4107 WILKENS AVE.</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 18 1982</b>		25b. REGISTRAR'S SIGNATURE <b>James J. [Signature]</b>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ANNIE E. JONES</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1 17 82</b>			2b. HOUR <b>9:05 AM</b>			
3 SEX <b>Female</b>		4 RACE <b>Black</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>5 29 1900</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>81</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore</b>			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Provident Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Domestic</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Pvt. Family</b>	
13a. STATE <b>Maryland</b>			13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST <b>Landon Bean</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Betty Jones</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			
16b. SOCIAL SECURITY NO. <b>212-32-2574</b>			17 INFORMANT <b>Baltimore Co. Maryland 21207</b>			17 ADDRESS <b>Mrs. Gloria H. Martin 5 Dauber Court</b>			
18 CAUSE OF DEATH: Enter only one cause for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>4275</b> IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b> DUE TO, OR AS A CONSEQUENCE OF: (b) _____ DUE TO, OR AS A CONSEQUENCE OF: (c) _____ CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>12/29 81</b> to <b>1/17 82</b> , that (I) (we) last saw the deceased alive on <b>1/11/82</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.									
22b. SIGNATURE <b>A. L. Brewer MD.</b>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1/17/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>A. L. BREWER</b>			22e. ADDRESS <b>2600 Liberty Heights</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>1/25/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Balto. Nat. Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Baltimore City Maryland</b>		
24. FUNERAL DIRECTOR NAME <b>Herbert E. Nutter</b>			ADDRESS <b>Baltimore 21216</b>			25a. DATE REC'D. BY REGISTRAR <b>JAN 18 1982</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 1 2 6

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Barbara E. Jones			2a. DATE OF DEATH MONTH DAY YEAR 1 30 82		2b. HOUR 6:30 P.M.	
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 8 30 1903		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 266 S. Loudon Ave.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md.			13b. COUNTY	13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John Brown			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS William A. Jones 266 S. Loudon Ave., 21229		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary artery Dis</u> <u>4100</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cardio Vascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>2 mo</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <u>Arthritis, Hernia</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>May 19 68</u> to <u>1-30-82</u> , that (I) <u>was</u> last saw the deceased alive on <u>Dec 28 19 81</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>was</u> did <u>not</u> view the body after death.						
22b. SIGNATURE <u>J. Nelson McKay M.D.</u>				22c. DATE SIGNED		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. Nelson McKay M.D., P.A.				22e. ADDRESS 1132 N. Rolling Road Baltimore, Maryland 28		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-3-82		23c. NAME OF CEMETERY OR CREMATORY Lakeview Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Carroll Md.
24. FUNERAL DIRECTOR NAME G. Truman Schwab, P.A.				25a. DATE REC'D. BY REGISTRAR FEB 3 1982		25b. REGISTRAR'S SIGNATURE <u>James J. [Signature]</u>





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (CITY OR TOWN, COUNTY, STATE)
Burial	1-14-82	Evergreen Memorial	Finksburg Carroll Md.
24. FUNERAL DIRECTOR (NAME)	25. DATE REC'D. BY REGISTRAR		26. REGISTRAR'S SIGNATURE
Fletcher Funeral Home	JAN 18 1982		Michael R. Kessler

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Empyema - overwhelming infection</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Aspiration</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Seizure</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>2 weeks</u> <u>2 weeks</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>La For's Disease</u>		
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from <u>12/28</u> , 19 <u>81</u> , to <u>1/10</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>1/10</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.		
22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Michael R. Kessler	MD	1/11/82
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS	
MICHAEL R. KESSLER M.D.	UNIV OF MD. Hosp.	

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>Craig Brian Jones</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>1 10 82</u>		2b. HOUR <u>1130 PM</u>
3. SEX <u>Male</u>	4. RACE <u>Caucasian</u>	5. DATE OF BIRTH MONTH DAY YEAR <u>10 08 59</u>	6. AGE (IN YEARS LAST BIRTHDAY) YRS <u>22</u>	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) <u>Baltimore</u>	7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u> MD.		
10. CITY OR TOWN OF DEATH <u>Baltimore MD</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>University of Maryland</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>None</u>	12b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
13a. STATE <u>MD</u>	13b. COUNTY <u>Carroll</u>	13c. CITY OR TOWN <u>Patesville Westminster</u>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <u>3747 Backwoods Rd.</u>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>Darrell W. Jones</u>	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Joyce Fauber</u>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>		
16b. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT ADDRESS <u>Joyce F. Jones same as #13</u>			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH-17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		5 2 0 1 1 2 8	
1. DECEASED NAME (TYPE OR PRINT)		2b. DATE KNOWN OF DEATH ESTI-MATED	
David W. Jones		xx MONTH DAY YEAR 1 13 19 82	
3. SEX	4. RACE	5. DATE OF BIRTH (MONTH DAY YEAR)	6. AGE (IN YEARS LAST BIRTHDAY)
Male	White	Sept. 5 1948	33 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	
Maryland		USA	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	
Baltimore		2111 Sidney Avenue	
13a. STATE		13b. COUNTY	
MD.		Balto.	
14. FATHER'S NAME (FIRST MIDDLE LAST)		15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)	
Edward C. Jones		Eva M. Cordell	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	
yes		VietNam 219 500 624	
17. INFORMANT		ADDRESS	
family records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Stab Wounds 9660 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. AUTOPSY?		YES XX NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 1:00xx 1 13 19 82	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		subject was stabbed	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home	
21f. LOCATION CITY OR TOWN COUNTY STATE 2111 Sidney Avenue, Baltimore, Maryland			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Virginia L. Dolan		TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.		ADDRESS 111 Penn Street	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 1/16/82	
23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. County Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Evans Funeral Chapel 8800 Harford Road		25a. DATE REC'D. BY REGISTRAR JAN 19 1982	

SP-3-21 NAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR		8 2 0 1 1 2 9 REG. NO.								
1. DECEASED NAME (TYPE OR PRINT) <b>ELIZABETH H. JONES</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>1 8 82</b>					2b. HOUR <b>9:50</b> a.m.
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3 24 03</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto. City</b> MD.				
10. CITY OR TOWN OF DEATH <b>Balto.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Long Green Nursing Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Secretary</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Paper</b>		
13a. STATE <b>Md.</b>		13b. COUNTY		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>6833 Bleinheim Road</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>William H. Hennighausen</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Bertha Denhart</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>212-07-5838D</b>		17. INFORMANT ADDRESS <b>5 Birch Road</b> <b>Mr. Herbert Jones West Simsberry, Conn.</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> <b>4360</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>generalized arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>MINUTE</b> <b>4 YRS</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>- Epilepsy, - Prionemia.</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>4-6-1969</b> , to <b>1-8-1982</b> , that (I) (we) last saw the deceased alive on <b>11-30-1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										
22b. SIGNATURE <b>Attentive M.D.</b>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>1-9-82</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>S.J. VENABLE JR M.D.</b>					22e. ADDRESS <b>7215 YORK RD. BALTIMORE MD - 21212</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>1-8-82</b>		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b>					ADDRESS <b>Balto., Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 14 1982</b>			
					25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					



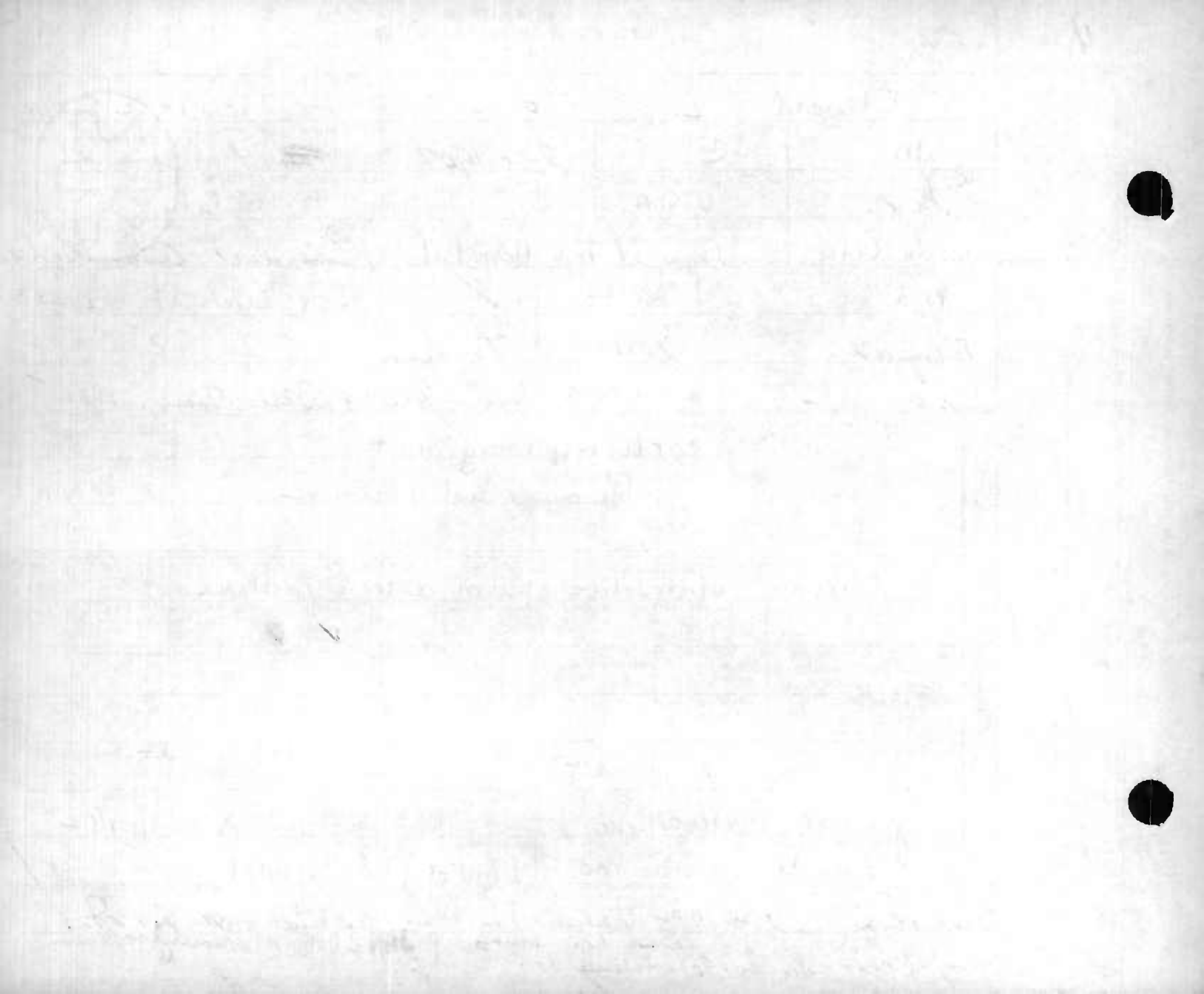


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 1 1 3 0	
1. FOR STATE REGISTRAR			REG. NO.								
1. DECEASED NAME (TYPE OR PRINT) <b>Elwood L. Jones</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1-17-82</b>		2b. HOUR <b>5:29 AM</b>						
3. SEX <b>M</b>		4. RACE <b>C</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8-20-1907</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 72 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN) <b>Ind.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto. City</b> MD.					
10. CITY OR TOWN OF DEATH <b>Balto. City</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Univ of Md Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Blender</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Greenwell Co.</b>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>md</b>		13b. COUNTY <b>Balto</b>		13c. CITY OR TOWN <b>Balto</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1208 James St. 21223</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Winfield Jones</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lillian ?</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. (IF YES, GIVE WAR OR DATES) <b>-</b>		17. SOCIAL SECURITY NO. <b>21301 8895</b>		18. INFORMANT ADDRESS <b>Wayne H. Jones 8 Pettibone Drive. 21225</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiorespiratory arrest</b> <b>4100</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>possible myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Chronic obstructive pulm disease / asthma</b> DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30-60 min.</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
<b>Chronic obstructive pulm disease / asthma</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>1/17</b> , 19 <b>82</b> , to <b>1/17</b> , 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>1/17</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Joan M. Bathon MD</b>						DEGREE <b>MD</b>		22c. DATE SIGNED <b>1/17/82</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Joan M. Bathon MD</b>						22e. ADDRESS <b>Univ of Md Hospital</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>1-20-1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview Mem. Ph.</b>		23d. LOCATION CITY OR TOWN STATE <b>Baltimore Bge. Co. Md.</b>					
24. FUNERAL DIRECTOR <b>Shant Connor &amp; Son, Inc. 901 Indiana St.</b>				25a. RECEIVED BY REGISTRAR <b>JAN 20 1982</b>		25b. SIGNATURE <b>Joan M. Bathon</b>					





1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 1 3 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>EMMA L. JONES</b>			2a. DATE OF DEATH MONTH <b>1</b> DAY <b>19</b> YEAR <b>82</b>			2b. HOUR <b>M</b>		
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH <b>May</b> DAY <b>6</b> YEAR <b>1895</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b> YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Oxford N.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto. City</b> MD.		
10. CITY OR TOWN OF DEATH <b>Balto.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1501 N. Payson St.</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
13a. STATE <b>Md.</b>								
13b. COUNTY <b>—</b>		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1501 N. Payson St.</b>		
14. FATHER'S NAME FIRST <b>George</b> MIDDLE <b>Hardy</b> LAST <b>Hardy</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Hallie</b> MIDDLE <b>Hardy</b> LAST <b>Hardy</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>219-50-7056</b>		17. INFORMANT ADDRESS <b>Alma C. Frazier-Hampton, Va</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>4029</b> IMMEDIATE CAUSE (a) <b>Hypertensive cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Diabetes mellitus</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Atherosclerotic Cardiovascular Disease</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10-15 yrs</b> <b>5 yrs</b> <b>5-10 yrs</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>3/28/78</b> to <b>1/19/82</b> that (I) (we) lost saw the deceased <b>die</b> on <b>6/14/81</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <b>E. L. Saunders</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1/24/82</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ELIJAH SAUNDERS</b>		22e. ADDRESS <b>21 HAMILL Rd Butler MD</b>						
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>		23b. DATE <b>1-23-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt Calvary</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brooklyn 4A Md</b>		
24. FUNERAL DIRECTOR NAME <b>Dwinnell B. Oden</b>		ADDRESS <b>Balto. Md</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 25 1982</b>		25b. REGISTRAR'S SIGNATURE <b>James W. Nathan</b>		

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The certificate should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

1 19 81

JONES

I.

MEM

Black

Female

Balto. City

x

Homemaker

1801 N. Payson St.

Balto.

1801 N. Payson St.

Balto.

212-62-7000



1985-1986

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 1 1 3 2 REG. NO.			
1. FOR STATE REGISTRAR				1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST			
EVELYN JONES				2c. DATE OF DEATH MONTH DAY YEAR 2b. HOUR			
JANUARY 28, 1982 7:40A							
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
4/30/28		53 YRS.		9. BALTIMORE CITY OR COUNTY OF DEATH			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTO.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST ARTHUR JONES		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LOUELLA PULLIAM					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS TERRYONE A. WILCOX 3808 Cedar Drive			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Laryngeal Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>1619</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>1/21/82</u> , 19 <u>82</u> , to <u>1/28</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>1/28</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>David Klassen</u> DEGREE <u>MD</u>				22c. DATE SIGNED <u>1/28/82</u>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>DAVID KLASSEN</u>	
22e. ADDRESS <u>JOHNS HOPKINS HOSP. BALTO. MD</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		23b. DATE <u>2/2/82</u>		23c. NAME OF CEMETERY OR CREMATORY <u>HILL CEM. CEDAR BLVD</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Glen Burnie Md.</u>	
24. FUNERAL DIRECTOR <u>W C MARCH F/H, Inc.</u> ADDRESS <u>1101 E. North Ave.</u>				25. DATE RECORDED BY STATE REGISTRAR <u>JAN 29 1982</u>			



17



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BP

DHMH-17  
(VR A15 ME (1))  
15M 2/80

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 5 2 0 1 1 3 3									
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Helen Jones								2a. DATE KNOWN OF DEATH xx MONTH DAY YEAR 1 15 1982		2b. HOUR M 6:45 P. M.							
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 6 7 07		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1 15 1982		2d. HOUR M 6:45 P. M.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.							
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Provident Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE MD				13b. COUNTY				13c. CITY OR TOWN Baltimore				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 2106 W. North Ave.			
14. FATHER'S NAME FIRST MIDDLE LAST Arthur Forester								15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST -											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-20-1815				17. INFORMANT ADDRESS Robin Jones Gee 1330 N. Fremont Ave											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE Virginia L. Dolan				TITLE (SPECIFY) M.D. Assistant				MEDICAL EXAMINER				DATE SIGNED 1-17-82							
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.				ADDRESS 111 Penn Street															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 1/21/82		23c. NAME OF CEMETERY OR CREMATORY King Memorial Pk.				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co. MD									
24. FUNERAL DIRECTOR NAME Wm. C. March F/H				ADDRESS 1101 E. North Ave.				25a. DATE REC'D. BY REGISTRAR JAN 18 1982				25b. REGISTRAR'S SIGNATURE [Signature]							



RECEIVED  
MAY 18 1894  
NEW YORK, N.Y.

JAN 18 1894

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

DHMH - 163/72 25M  
(VR A15 (4))

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MEDICAL CERTIFICATION

1. DECEASED-NAME (Type or print) <b>JAMES R. JONES</b>		2a. DATE OF DEATH Month <b>1</b> Day <b>24</b> Year <b>82</b>		2b. HOUR <b>11:30 AM</b>
3. SEX <b>MALE</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH <b>9-25-07</b>		6. AGE (In years last birthday) <b>74</b> YRS.
7a. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Baltimore City</b> Md.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Chloroform NH</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>TRUCK DRIVER</b>	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD</b>	13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>1419 Poplar Grove St</b>
14. FATHER'S NAME First Middle Last <b>Thomas Jones</b>	15. MOTHER'S MAIDEN NAME First Middle Last <b>Eli Jones</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	16b. SOCIAL SECURITY NO. <b>25-07-2830A</b>	17. INFORMANT Address <b>Mrs. Mary Spratley 4002 Rosecrest Ave.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF <b>ASEVD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS CONTRIBUTING <input type="checkbox"/> UNDERLYING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <b>11/24/79</b> , 19____, to <b>1/24/82</b> , 19____, that (I) (we) last saw the deceased alive on <b>1/24/82</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <b>James L. Jones</b>	DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED <b>12/25/82</b>		
22d. PHYSICIAN'S NAME (Type) <b>HORNS PENNINGTON, MD</b>	22e. ADDRESS <b>5010 York Rd Baltimore, Md 21207</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>1-29-82</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Kings Mem. Park</b>	23d. LOCATION (City or Town) (County) (State) <b>BALTO. Co. MD</b>	
24. FUNERAL DIRECTOR <b>Joseph L. Reuss</b>	ADDRESS <b>2522 W. North Ave.</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 27 1982</b>	25b. REGISTRAR'S SIGNATURE <b>Anna J. [Signature]</b>

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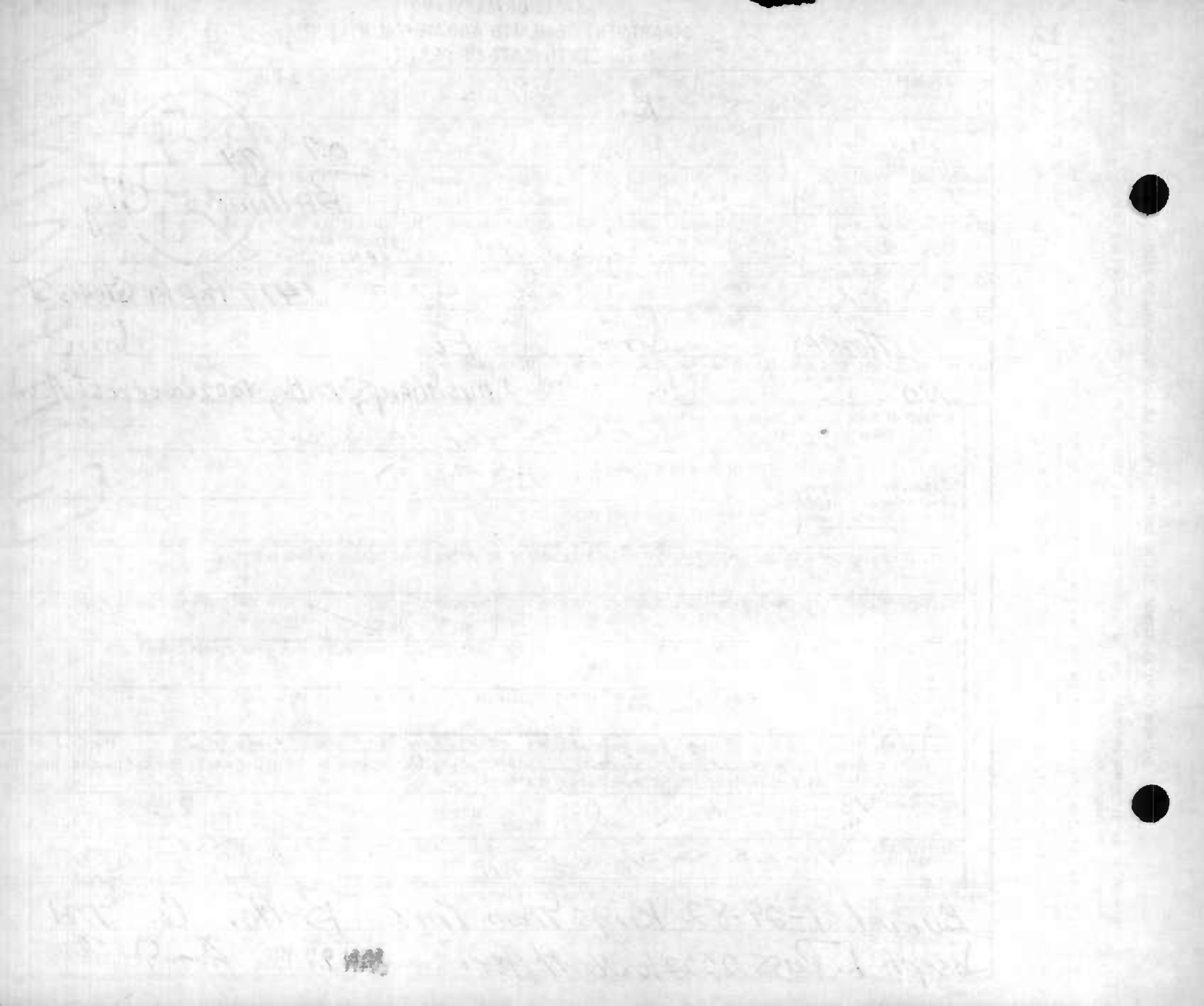
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 1 3 5

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MINNIE N. JONES			2a. DATE OF DEATH MONTH DAY YEAR 1 7 82		2b. HOUR 11:05A.M.						
3 SEX Female		4 RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 5 8 93		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10 CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Provident Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2200 Ruskin Avenue			
14. FATHER'S NAME FIRST MIDDLE LAST Billy Jones				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Harriett Scott							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 224-72-7154		17 INFORMANT ADDRESS Nannie Clements 2200 Ruskin Avenue					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest - asystole</u> 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>1 day</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 1-7, 19 82, to 1-7, 19 82, that (I) (we) last saw the deceased alive on 1-7, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Denise Bell, M.D.				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 1-7-82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Denise Bell, M.D.				22e. ADDRESS Provident Hospital 2600 Liberty Hgts Ave.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/11/82		23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD					
24 FUNERAL DIRECTOR NAME Wm. C. March F/H				ADDRESS 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR JAN 8 1982		25b. REGISTRAR'S SIGNATURE [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

No.		Date		Locality		Collector		Plant		Remarks	
1		1912	May 15	California							
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UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.  
1912



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 1 3 6

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>VIOLA SERINA JONES</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JANUARY 4, 1982</b>		2b. HOUR <b>10:00P</b>
3. SEX <b>Female</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Mar. 7, 1952</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>29</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>JOHNS HOPKINS HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Secretary</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Mobile Homes</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>Maryland</b>			13b. CITY OR TOWN <b>Harford</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
13d. STREET ADDRESS <b>904 Topview Drive</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Lloyd Andrew Harris</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Louise Anna Norton</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>215-58-2739</b>		17. INFORMANT ADDRESS <b>Worthington Jones, Edgewood, Md.</b>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory arrest</b> 3488 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Brain lesion, etiol unknown</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>TTP</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30 min</b> <b>4-5 hrs.</b> <b>1 wk.</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) <b>anemia, thrombocytopenia</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (SAY HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>1/4/82</b> 19 <b>82</b> to <b>1/4/</b> 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>1/4/</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.					
22b. SIGNATURE <b>Carl Schultz, M.D.</b>		DEGREE		22c. DATE SIGNED <b>1/4/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>CARL SCHULTZ, M.D.</b>		22e. ADDRESS <b>JHH, BALTIMORE, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>Jan. 9, 1982</b>	23c. NAME OF CEMETERY OR CREMATORY <b>John Wesley U.Meth.Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Abingdon Harford Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Howard K. McComas III, Abingdon, Md.</b>		ADDRESS		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>JAN 7 1982 James J. Nathan</b>	

MEDICAL CERTIFICATION

9

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP





Handwritten text, possibly a signature or name, appearing as "Tina" or "Tina" with a flourish.

Handwritten checkmark or symbol.

Handwritten text, possibly a date or time, appearing as "10/10/10" or similar.

Handwritten text, possibly a signature or name, appearing as "Tina" or "Tina" with a flourish.

Handwritten text, possibly a signature or name, appearing as "Tina" or "Tina" with a flourish.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

82 01137

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>William Jones</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>1 12 82</i>			2b. HOUR <i>7:28 AM</i>	
3. SEX <i>Male</i>		4. RACE <i>Black</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>8 25 41</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>40</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Balt. City</i> MD.	
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Provident Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE <i>Maryland</i>		13b. COUNTY		13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Frederick Jones</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Ida E. Buckner</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>No</i>		16b. SOCIAL SECURITY NO. <i>213-36-6657</i>		17. INFORMANT ADDRESS <i>Emma Mae Cooper-same as above</i>			

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Arrest</i> 53335 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Adult Respiratory Distress Syn.</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <i>Cardiac Failure</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Hypertension, Hypercholesterolemia</i>					
19a. DATE OF OPERATION <i>1/4/82</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Refractory Peptic Ulcer</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>PM 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>1/3</i> , 19 <i>82</i> , to <i>1/12</i> , 19 <i>82</i> , that (I) (we) last saw the deceased <i>alive</i> on <i>1/12</i> , 19 <i>82</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.					
22b. SIGNATURE <i>Ronald D. Miles</i>		DEGREE <i>M.D.</i>		22c. DATE SIGNED <i>1/12/82</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Ronald D. Miles</i>		22e. ADDRESS <i>Provident Hosp</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>1-16-82</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Auburn</i>	
23d. LOCATION CITY OR TOWN COUNTY STATE <i>Balto. (Westport) Md.</i>		24. FUNERAL DIRECTOR NAME ADDRESS <i>CHAS. A. RICE FSPA 1300 Eutaw Pl.</i>			
25a. DATE REC'D. BY REGISTRAR <i>JAN 18 1982</i>		25b. REGISTRAR'S SIGNATURE <i>James J. ...</i>			

526:4.141

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
William JONES JR.					1-31-82 1 PM				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE		7. IF UNDER 1 YEAR	
MALE		BLACK		12 12 38		49 43 YRS.		MONTHS DAYS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		9. CITIZEN OF WHAT COUNTRY?		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH			
Md.		USA				City MD.			
12. CITY OR TOWN OF DEATH		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		15. KIND OF BUSINESS OR INDUSTRY	
Balto.		LUTHERAL Hosp. of Md.							
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					17. INSIDE CITY LIMITS?				
13a. STATE 13b. COUNTY 13c. CITY OR TOWN					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
Md. Balto. City									
18. FATHER'S NAME					19. MOTHER'S MAIDEN NAME				
WILLIAM JONES, SR.					CLARA Young				
20. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)					21. SOCIAL SECURITY NO.				
yes					220 241 954				
23. INFORMANT ADDRESS					24. CLARA JONES 3405 Carlisle Ave.				
25. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Cardio respiratory arrest									
4275 DUE TO, OR AS A CONSEQUENCE OF									
(b)									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
26. DATE OF OPERATION									
27. CONDITION FOR WHICH OPERATION WAS PERFORMED									
28. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>									
29. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
30. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
31. TIME OF INJURY HOUR A.M. MONTH DAY YEAR									
F.M. 19									
32. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II)									
33. INJURY OCCURRED									
34. PLACE OF INJURY (A HOME, STREET, FACTORY, OFFICE, FARM, ETC.)									
35. LOCATION (STREET CITY OR TOWN COUNTY STATE)									
36. I certify that (I) (this hospital) attended the deceased from 12/7 19 81 to 1/31 19 82, that (I) (we) last saw the deceased alive on 1/31 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If true) (did) (did not) view the body after death.									
37. SIGNATURE									
DEGREE									
38. DATE SIGNED									
39. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>									
40. PHYSICIAN'S NAME (TYPE OR PRINT)									
Henry J. Sackner									
41. ADDRESS									
Lutheran Hospital of Maryland									
42. BURIAL, CREMATION, REMOVAL (SPECIFY)									
burial									
43. DATE									
2/4/82									
44. NAME OF CEMETERY OR CREMATORY									
King Memorial PK									
45. LOCATION CITY OR TOWN COUNTY STATE									
Balto., Md.									
46. FUNERAL DIRECTOR NAME ADDRESS									
Leroy O. Dyett 4600 Liberty Hgts Ave									
47. DATE REC'D. BY REGISTRAR									
FEB 3 1982									
48. REGISTRAR'S SIGNATURE									
Renee Jean Martin									

27

Handwritten notes in the upper section of the lined paper, including several lines of text and a small 'x' mark.

Handwritten notes in the middle section of the lined paper, featuring a large circular diagram with internal lines and text.

Handwritten notes in the lower section of the lined paper, including a large rectangular diagram with internal lines and text.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please reattach pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 1 1 3 9	
FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>ALBERT William JORDAN</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>JANUARY 11, 1982</b>				2b. HOUR <b>9:53 PM</b>	
1. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 24, 1930</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>51</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS <b>11 11</b>		IF UNDER 24 HRS. HOURS MIN. <b>9 53</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Hobart, Indiana</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.					
10. CITY OR TOWN OF DEATH <b>Balto.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Hardware Store Owner</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>						13b. COUNTY <b>Queen Anne.</b>		13c. CITY OR TOWN <b>Queenstown</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Jabez Jordan</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anne Hanley</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>				16b. SOCIAL SECURITY NO. <b>213-28-1820</b>		17. INFORMANT <b>Marjorie Ann Jordan</b>		ADDRESS <b>Rt. #1 Box 149-A Queenstown, Md. 21658</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Peep arrest</b> <b>1539</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Melastate Colon Ca</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 min</b> <b>2 hrs</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>1/1/82</b> , 19 <b>82</b> , to <b>1/11</b> , 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>1/11</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>M.G. Midei</b>				DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1/11/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>M.G. Midei</b>				22e. ADDRESS <b>600 N. Wolfe St., Balt. MD 21205</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>1-15-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Memorial Park</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Easton Talbot Md.</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>Helfenbein-Hubbard F.H. Chester, Md. 21619</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 18 1982</b>					
						25b. REGISTRAR'S SIGNATURE <b>James J. Tharion</b>					

CONFIDENTIAL  
NO FORN DISSEM  
EXCEPT BY AUTHORITY

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SECRET

STATE DEPARTMENT

INFORMATION REPORT

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>John F. Jordon</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1 11 1982</b>			2b. HOUR <b>M</b>				
3. SEX <b>Male</b>		4. RACE <b>Cauc.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9 1 1915</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>YRS.</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ohio</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>213 N. Luzerne Ave.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Medical Spec.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Army</b>		
13a. STATE <b>Md.</b>					13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Unknown</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unknown</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>Korean 182-32-1733</b>		17. INFORMANT ADDRESS <b>Mauricette Jordon 213 N. Luzerne Ave</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>2500</b> IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Diabetes and Complications</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) <u>the hospital</u> attended the deceased from <u>12/31</u> , 19 <u>80</u> , to <u>1/13/82</u> , that (1) <u>we</u> lost saw the deceased alive on <u>12/31</u> , 19 <u>81</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (1) <u>we</u> <u>did not</u> view the body after death.										
22b. SIGNATURE <b>M Rendell MD</b>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>1/13/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Marc Rendell MD</b>						22e. ADDRESS <b>3100 Wyman Park Drive</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>1/14/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Crownsville Vet. Cem</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Anne Arundel Md.</b>		
24. FUNERAL DIRECTOR NAME <b>B. Dabrowski &amp; son 2818 E. Baltimore St.</b>						25. DATE REC'D. BY REGISTRAR <b>JAN 18 1982</b>				



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 10 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

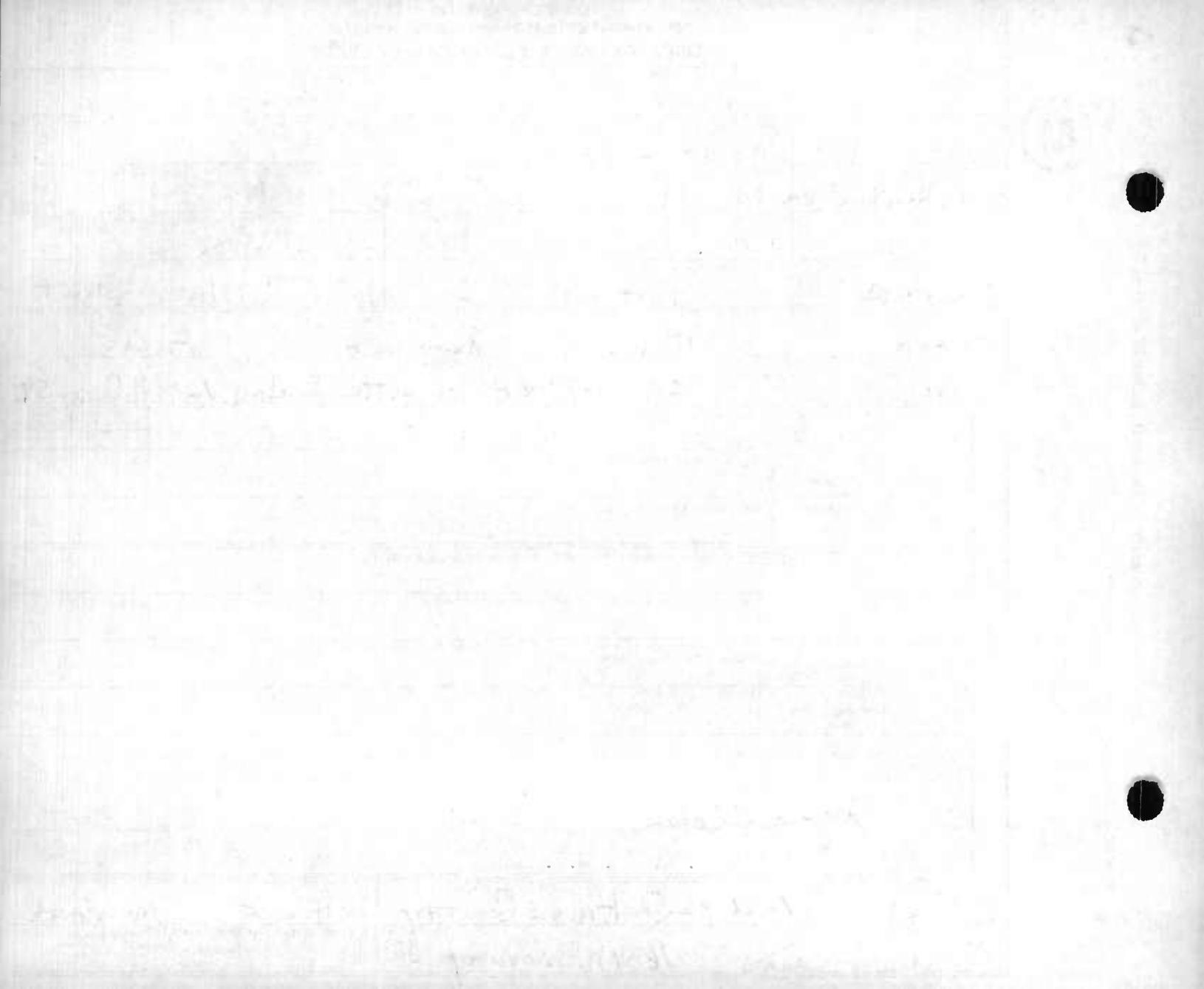
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (CITY OR TOWN)	COUNTY	STATE
Burial	1-21-82	Baltimore Cemetery	Baltimore		Maryland
24. FUNERAL DIRECTOR (NAME)	ADDRESS		25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE	
W. Dean J. Spaul	1639 N. Broadway		JAN 18 1982	[Signature]	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
(b) _____ DUE TO, OR AS A CONSEQUENCE OF		
(c) _____ DUE TO, OR AS A CONSEQUENCE OF		

## PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .		
ACTUAL SIGNATURE <u>Virginia L. Dolan</u>	TITLE (SPECIFY) M.D. Assistant	MEDICAL EXAMINER
EXAMINER'S NAME (TYPE OR PRINT)	ADDRESS	
Virginia L. Dolan, M.D.	111 Penn Street	

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 5 2 0 1 1 4 1	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Reba Jordan										2a. DATE KNOWN OF DEATH ESTI-MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1 14 19 82	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 10-3-02		6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. 79		IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1 15 19 82	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Hampton Co., VA.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.	
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1621 E. Oliver Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House Wife		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland										13b. COUNTY	
13c. CITY OR TOWN Baltimore										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 1621 E. Oliver Street											
14. FATHER'S NAME FIRST MIDDLE LAST Frank Withney					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rebecca Fields						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO					16b. SOCIAL SECURITY NO. 217-09-7700A					17. INFORMANT ADDRESS Georgette Jordan 1238 N. Curley St.	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
FIRST MIDDLE LAST <i>Prothy C. Joynes</i>					MONTH DAY YEAR <i>1-29-82</i>				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7b. HOUR	
Female		Black		MONTH DAY YEAR <i>8-3-32</i>		49 YRS.		<i>1:29</i> AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Balto., Md.		USA				Baltimore MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Balto.		Bon Secours Hospital							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS?				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13e. STREET ADDRESS			
Md.				Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 1718 Thomas Ave.			
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
James Carnegie					Mable Carnegie				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS					
No		218 26 9289		George Joynes 1718 Thomas Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio-pulmonary Arrest</i> <i>4039</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) <i>Ventricular Tachycardia - Fibrillation</i> (c) <i>Hypertensive Cardiovascular Disease</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <i>Hypertension; Chronic Renal failure; Diabetes Mellitus; obesity</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>1/18/82</i> , 19 <i>82</i> , to <i>1/29/82</i> , 19 <i>82</i> , that (I) ( <del>we</del> ) lost saw the deceased alive on <i>1/28</i> , 19 <i>82</i> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.									
22b. SIGNATURE <i>H. K. Bhasin</i>				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <i>1/29/82</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>HARI K. BHASIN M.D.</i>				22e. ADDRESS <i>606 HAMMONDS LANE BALTO MD 21225</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
burial		2/2/82		Mt. Calvary Cem.		Balto., Md.			
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
<i>LEROY DYETT F.O.H.</i>				4606 Liberty Hill		FEB 1 1982 <i>Frances Jan. Nathan</i>			

MEDICAL CERTIFICATION

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DHMH - 16 50M 1/B1  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8201143			
1. DECEASED NAME (TYPE OR PRINT) <i>Sylvia Joyner</i>				2a. DATE OF DEATH MONTH DAY YEAR 1/19/82			
3. SEX <i>FEMALE</i>		4. RACE <i>black</i>		5. DATE OF BIRTH MONTH DAY YEAR 01 30 10		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>North Carolina</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.	
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Greater Penn. Ave. Nursing Home</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <i>Md.</i> 13b. COUNTY <i>PG.</i> 13c. CITY OR TOWN <i>Seat Plea.</i>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>516 67 Pl. Seat Plea. Md.</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Jobe Jackson</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Bertha Nun</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>			
16b. SOCIAL SECURITY NO. <i>240-66-3853</i>		17. INFORMANT ADDRESS <i>Blanch Malloy same as 13e</i>					
18. CAUSE OF DEATH (Enter only one cause per line. (a) only. PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Heart Failure</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 MIN</i>			
4029							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertension</i>							
(c) DUE TO, OR AS A CONSEQUENCE OF							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <i>Chronic Bronchitis</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (i) (this hospital) attended the deceased from <i>01-16-81</i> to <i>01-19-82</i> , that (i) (we) last saw the deceased alive on <i>01-15-82</i> , and that it (my) (our) opinion death occurred on the date and hour and from the causes stated above; (ii) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Richard Tyson, M.D.</i> DEGREE <i>M.D.</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <i>01-19-82</i>			
22d. THE SIGNER'S NAME (TYPE OR PRINT) <i>RICHARD TYSON, M.D.</i>				22e. ADDRESS <i>936 W. NORTH AV. BALTO MD 21217</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>burial; removal</i>		23b. DATE <i>1-22-82</i>		23c. NAME OF CEMETERY OR CREMATORY <i>South View Cem.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Kinston, North Carolina</i>	
24. FUNERAL DIRECTOR <i>FRAZIER'S</i> ADDRESS <i>389 R.I. Ave. NW</i>				25a. DATE REC'D. BY REGISTRAR <i>JAN 21 1982</i> 25b. REGISTRAR'S SIGNATURE <i>Frances Jan Nathan</i>			





*[Faint, illegible handwriting on lined paper]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. For the certificate to be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 6 8566 4/21/82 83

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 1 4 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>WALTER KACEY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1 31 82</b>			2b. HOUR <b>2:15 A.M.</b>	
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 2 18</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>63-64</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1817 WILHELM AVENUE</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>TEACHER</b>	
13a. STATE <b>MD</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>WALTER J. KUCEWICZ</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>NELLIE WAXNER</b>		13e. STREET ADDRESS <b>1817 Wilhelm Ave</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>W.W.II 066-16-1462</b>		17. INFORMANT ADDRESS <b>DOROTHY KACEY 1817 WILHELM MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-respiratory failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Metastatic Anaplastic Cancer</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>July 22</b> , 19 <b>80</b> , to <b>Jan 31</b> , 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>Jan 26</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Allen G. Meek</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>1-31-82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ALLEN G. MEEK</b>				22e. ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>		23b. DATE <b>2-2-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MAPLE HILL CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>HANOVER TWP. LUZERNE PA</b>	
24. FUNERAL DIRECTOR NAME <b>M. J. McLAUGHLIN CO.</b>				ADDRESS <b>1425 WASHINGTON ST</b>		25a. DATE REC'D. BY REGISTRAR <b>2-4-82</b>	
				25b. REGISTRAR'S SIGNATURE <b>Juanita Martin</b>			

MEDICAL CERTIFICATION

29

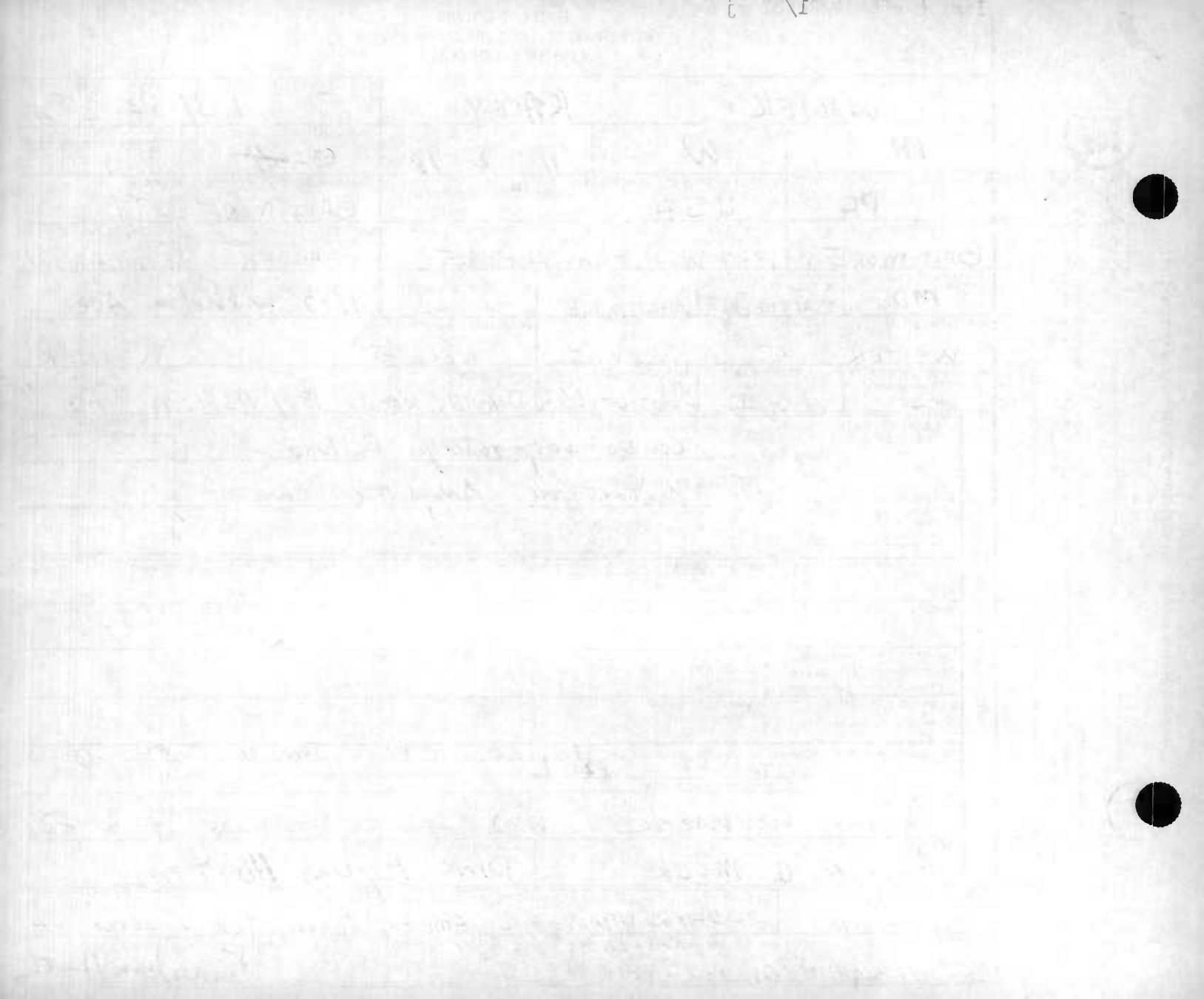
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1903 BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP \_\_\_\_\_

DHMH - 17  
(VR A15 ME (1))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR			
Emilie						Kaiss		1-9-82		19						M			
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR	
female	white	10 - 31 - 1900		81 YRS.						1-9-82		19						12:10 P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
Estonia		Estonia						Baltimore City										MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY													
Baltimore		St. Agnes Hospital		Homemaker															
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS											
Maryland		BALTO.		Baltimore		-YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2941 Freeway, 21227											
14. FATHER'S NAME		FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		FIRST		MIDDLE		LAST					
Kaarel						Linnamagi		Maali						Mottus					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
No		279-30-1729D		Ms. Silvia Raudvere, same as #13e															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: (b) _____ (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE <u>Margareta A. Korrell</u>		TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER		DATE SIGNED 1-10-82													
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS																	
Margarita A. Korrell, M.D.		111 Penn Street																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE													
Burial		1-14-82		Parkwood Cemetery		Parkville, Maryland													
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
Leonard J. Ruck, Inc.		5305 Harford Rd. Balto. Md.		JAN 11 1982		Francis Jan Nathan													

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10/10/10

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10/10/10

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 201146	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DONTAVIA M. KALOKO KAKOLO										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 1 7 19 82	
3. SEX female		4. RACE negro		5. DATE OF BIRTH MONTH DAY YEAR 10 6 81		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 3		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2b. HOUR M 12:38	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		2c. DATE PRONOUNCED DEAD 1 7 19 82		2d. HOUR D M	
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2234 Frederick Ave.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Baby		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md			13b. COUNTY -		13c. CITY OR TOWN Balto		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2234 Frederick Ave		
14. FATHER'S NAME Patrick			MIDDLE		LAST Kaloko		15. MOTHER'S MAIDEN NAME Elizabeth M. Pounds		MIDDLE LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT Elizabeth Pounds - 2234 Frederick Ave		ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden Infant Death Syndrome 7980 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Ann M. Dixon				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER				DATE SIGNED 1-7-82			
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St.							
23a. BURIAL, CREMATION, REMOVAL				23b. DATE 1/9/82		23c. NAME OF CEMETERY OR CREMATORY Western Mt. Md.		23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Balto. Ind.			
24. FUNERAL DIRECTOR NAME Kenneth B. Allen				ADDRESS Balto. Md.		25a. DATE REC'D. BY REGISTRAR JAN 11 1982		25b. REGISTRAR'S SIGNATURE [Signature]			

W. & C. COLLIER,

NEW YORK

*W. & C. COLLIER*

W. & C. COLLIER



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 1 1 4 7			
1. FOR STATE REGISTRAR										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>BARBARA M. KALTENBACH</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>January 17th, 1982</b>				2b. HOUR M			
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 18, 1887</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>94</b>		IF UNDER 1 YEAR MONTHS DAYS YRS.		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Baltimore, Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>							
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF IN JAIL, JAIL FACILITY, OR RESIDENTIAL NURSING HOME) <b>4000 N. Charles St. Apt. 310</b>				12a. USUAL OCCUPATION (IF IN JAIL, JAIL FACILITY, OR RESIDENTIAL NURSING HOME) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>				13b. COUNTY <b>Balto City</b>		13c. CITY OR TOWN <b>Balto City</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>4000 N. Charles Street 18</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph Moorman</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Scherder</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>215-09-42993</b>		17. INFORMANT ADDRESS <b>Miss Mary Kaltenbach-4000 N. Chas. St.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <b>ARTERIOSEPTAL PECTIC CARDIOVASC. DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Acute</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>January 10, 19 70</b> to <b>Jan 17, 19 82</b> , that (I) (we) last saw the deceased alive on <b>Jan 16, 19 82</b> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated.													
22b. SIGNATURE OF PHYSICIAN <b>Charles E. Carr, M.D.</b>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1/18/82</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Charles E. Carr, M.D.</b>						22e. ADDRESS <b>3900 N. Charles Street</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>Jan. 20, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cathedral Cem.</b>		23d. LOCATION (IF KNOWN) CITY COUNTY STATE <b>Balto City</b>					
24. FUNERAL DIRECTOR <b>Mitchell-Wiedefeld Home-6500 York Rd. 21212</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 20 1982</b>		25b. REGISTRAR'S SIGNATURE <b>Kenneth J. Nathan</b>					

January 17, 1952

SARAH H. HARRINGTON

White  
Chicago, Ill.  
1000 N. Dearborn St. Apt. 210  
Chicago, Ill.

Mr. J. Edgar Hoover  
Federal Bureau of Investigation  
Washington, D. C.

Dear Mr. Hoover:

I am writing to you to inform you that I have been advised by the Chicago Police Department that you are interested in the case of Sarah H. Harrington.

Very truly yours,  
Sarah H. Harrington

Enclosed for you are two copies of a letterhead memorandum dated and captioned as above.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) William J. Kaptain			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1 1 19 82			2b. HOUR 9:00 AM	
3. SEX male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 11/14/1933	6. AGE (IN YEARS) (LAST BIRTHDAY) 48 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1 1 19 82	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTIMORE		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore MD.		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH PLACE, GIVE STREET ADDRESS) 2800 Blk Orleans Street			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLERK		12b. KIND OF BUSINESS OR INDUSTRY SALES
13a. STATE MARYLAND		13b. COUNTY -----		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN J. KAPTAIN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HELEN ZIOLOKOWSKI					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) KOREN WAR		17. INFORMANT ADDRESS 21224 JOANNE DAY 2816 ORLEANS ST. BALTO. MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 8809 IMMEDIATE CAUSE (a) Cranio-cerebral injury DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Acute ethanol intoxication & Cirrhosis liver							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8:30 AM 1/1 19 82		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2). fell down steps			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 2800 Blk Orleans Street, Baltimore, MD			
22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> , inspection <input type="checkbox"/> , inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .							
ACTUAL SIGNATURE H. Shand		TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER				DATE SIGNED 1/1/82	
EXAMINER'S NAME (TYPE OR PRINT) hormez R. Guard, M.D.		ADDRESS 111 Penn Street, Balto. MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1/5/1982		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR NAME Dippel Funeral Homes, Inc.		ADDRESS 7110 Belair Road Baltimore, Md.		25a. DATE REC'D. BY REGISTRAR JAN 4 1982			
25b. REGISTRAR'S SIGNATURE James J. Thayer							

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1891

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 2 0 1 1 4 9	
1. FOR STATE REGISTRAR		CERTIFICATE OF DEATH								REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>DORA KAUTSCH</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>1-18-82</i>			2b. HOUR <i>2 45 P.M.</i>			
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>5-31-1895</i>		6. AGE (IN YEARS (LAST BIRTHDAY)) <i>86</i>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		7. BALTIMORE CITY OR COUNTY OF DEATH <i>Balto. C. Ty</i> MD.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Balto. Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Balto. C. Ty</i> MD.					
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Lutheran Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Seamstress</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <i>Md.</i>		13b. COUNTY		13c. CITY OR TOWN <i>Balto.</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>2131 E. Oliver Street - 21213</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>John Kautsch</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Kunigunda Leicht</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>				16b. SOCIAL SECURITY NO. <i>212-01-9459 A</i>		17. INFORMANT ADDRESS <i>Miss Dorothea K. Quick - 6909 Donachi Rd. Apt. D 21239</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory arrest</i> 5789 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Sepsis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <i>GI bleeding</i> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>12/1/82</i> to <i>1/18/82</i> , that (I) (we) lost <i>12/1/82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Henry J. Sacerin</i>				DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>1/18/82</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Henry J. Sacerin</i>				22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				23b. DATE <i>1-20-82</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Baltimore Cemetery</i>			23d. LOCATION CITY OR TOWN COUNTY STATE <i>Balto. Md.</i>		
24. FUNERAL DIRECTOR NAME <i>John C. Miller Inc-6415 Belair Rd.-21206</i>						25a. DATE REC'D. BY REGISTRAR <i>JAN 19 1982</i>		25b. REGISTRAR'S SIGNATURE <i>Thomas J. Martin</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the Registrar of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>ANNA F. KEAGLE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1 - 6 - 82</b>			2b. HOUR <b>10:55P M</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 29, 1893</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>UNION MEMORIAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>At, Home</b>	
13a. STATE <b>Md/</b>				13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Neauman</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Emma -</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>216-28-0227</b>		17. INFORMANT ADDRESS <b>Mrs. Emma Kelly 4338 Shamrock Avenue</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>4360</b> IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b> DUE TO, OR AS A CONSEQUENCE OF: (b) <b>Hypertension</b> DUE TO, OR AS A CONSEQUENCE OF: (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>4360</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>25 days</b> <b>4 yrs</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Probable RML Aspiration Pneumonia</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>12-11</b> , 19 <b>81</b> , to <b>1-6</b> , 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>1-6</b> , 19 <b>82</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.							
22b. SIGNATURE <b>Alvin R. Sills</b> 22c. DATE SIGNED <b>1/6/82</b>				22d. ADDRESS <b>UNION MEMORIAL HOSPITAL</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Jan. 9, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Most Holy Redeemer</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Leonard J. Ruck Inc. Baltimore, Maryland</b>				25a. DATE REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>JAN 7 1982</b> <b>Francis J. Nathan</b>			



10-8-51

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10-8-51

BALTIMORE CITY

UNION MEMORIAL HOSPITAL

BALTIMORE



UNION MEMORIAL HOSPITAL

ALVIN R. BILLS, M.D.

JAN 7 1952

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a report obtained.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		1 4 82		M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS (LAST BIRTHDAY))	
Female		Blk		5 26 29		52 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
83 Virginia		USA		Baltimore City		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
40 Balto.		St. Agnes Hospital		Unemployed		UNK	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
md.		Balto City		Balto		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
James		Valerie		NO		229-28-3962	
17. INFORMANT		ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DIR Betty Tolson		39 35 So. Cross Balto.		PART I. DEATH WAS CAUSED BY:			
				IMMEDIATE CAUSE (a) Intracerebral hemorrhage			
				DUE TO, OR AS A CONSEQUENCE OF (b) Ruptured Berry Aneurysm			
				DUE TO, OR AS A CONSEQUENCE OF (c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		22c. DATE SIGNED			
BERT F. MORTON		M.D.					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			
BERT F. MORTON							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		1/9/82		Church Com		Heathsville VA	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
VERNON BAILEY		6 1982		James Jean Nathan			

(1925)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	2	0	1	1	5	2
1. FOR STATE REGISTRAR										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Robert F. Kehs</b>										2a. DATE OF DEATH MONTH DAY YEAR <b>1 21 82</b>				2b. HOUR <b>M</b>		
3. SEX <b>Male</b>			4. RACE <b>White</b>			5. DATE OF BIRTH MONTH DAY YEAR <b>6 8 1910</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS.				IF UNDER 1 YEAR MONTHS DAYS <b>0 0</b>		IF UNDER 24 HRS. HOURS MIN. <b>0 0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto. City</b> MD							
10. CITY OR TOWN OF DEATH <b>Balto.</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>521 Chestnut Hill Ave.</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clerk</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>				
13a. STATE <b>Md.</b>			13b. COUNTY <b>Balto.</b>			13c. CITY OR TOWN <b>Balto.</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>521 Chestnut Hill Ave.</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Winfield M. Kehs</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth Contee</b>										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)						16b. SOCIAL SECURITY NO. <b>212-09-0897</b>			17. INFORMANT ADDRESS <b>James E. Wiest, 521 Chestnut Hill Ave.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aspiration pneumonia</b> <b>4360</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CVA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b> <b>4 months</b>																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>11/9 82</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <b>12/1/81</b>										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>12/1/81</b>			21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>1/21 82</b>										
22a. I certify that (this hospital) attended the deceased from <b>11/9 82</b> to <b>1/21 82</b> , that (I/we) last saw the deceased alive on <b>11/9 82</b> , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above, (I/we) (did/did not) view the body after death.																
22b. SIGNATURE <b>Stuart B. Bell</b>						DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>1/22/82</b>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Stuart B. Bell, M.D.</b>						22e. ADDRESS <b>3501 St. Paul St., Balto., Md. 21218</b>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>1/25/82</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. Md.</b>							
24. FUNERAL DIRECTOR NAME ADDRESS <b>Eugenia K. Seitz, 2303 Pentland Dr. 21234</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 26 1982</b>			25b. REGISTRAR'S SIGNATURE <b>James E. Wiest</b>							

2010

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Katie</b> FIRST <b>K.</b> MIDDLE LAST <b>KEIFER</b>										2a. DATE OF DEATH MONTH <b>JAN.</b> DAY <b>20</b> YEAR <b>82</b>		2b. HOUR <b>10<sup>30</sup></b> A.M.	
3. SEX <b>Female</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH <b>4</b> DAY <b>30</b> YEAR <b>1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.							
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Lafayette Square Nursing Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housekeeper</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>md.</b>		13b. COUNTY <b>-</b>		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>201 N. Broadway Balto. md.</b>					
14. FATHER'S NAME FIRST <b>Charles</b> MIDDLE <b>CLIFFORD</b> LAST <b>A. FOX</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Mary</b> MIDDLE <b>E.</b> LAST <b>WALKER</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>233 46 39 48</b>		17. INFORMANT <b>Hazel Williams</b>		ADDRESS <b>517 S. Chapel St.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiorespiratory Arrest</b> <b>4110</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary Insufficiency</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Generalized Arteriosclerosis</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5'</b> <b>5 yrs.</b> <b>10 yrs.</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b></b>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <b>6/16</b> 19 <b>81</b> to <b>1/20</b> 19 <b>82</b> that (I) (we) lost the deceased alive on <b>1/12</b> 19 <b>82</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>R. Reider</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1-20-82</b>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RUBEN REIDER</b>		M.D.		22e. ADDRESS <b>1406 Crain Highway South-Side 102</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Jan. 22, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Anne Arundel Co.</b> COUNTY <b>MD.</b> STATE <b>MD.</b>							
24. FUNERAL DIRECTOR NAME <b>Lilly &amp; Zeiler Inc.</b>				ADDRESS <b>1901 Eastern Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 26 1982</b>		25b. REGISTRAR'S SIGNATURE <b>James J. [Signature]</b>					

X

Wesley Williams 51 N. Grand St.

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Jan 22



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 0 1 1 5 4			
FOR 1. STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <u>THEODORE KELLAM</u>				2a. DATE OF DEATH MONTH DAY YEAR <u>1 14 82</u>		2b. HOUR <u>2:30 P.M.</u>	
3. SEX <u>M</u>		4. RACE <u>B</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>7 17 49</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>32</u> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>NEW YORK</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>CITY</u> MD.	
10. CITY OR TOWN OF DEATH <u>Baltimore</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>UNIVERSITY</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>INSTRUCTOR</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>COMPUTER</u>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13a. STATE <u>MARYLAND</u>		13b. COUNTY <u>Baltimore</u>		13c. CITY OR TOWN <u>Baltimore</u>		13e. STREET ADDRESS <u>3022 Woodland Ave</u>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>THEODORE</u> <u>NEWKIRK</u>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>EVELYN</u> <u>KELLAM</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b. SOCIAL SECURITY NO. <u>216-50-3236</u>		17. INFORMANT ADDRESS <u>Joyce A. Kellam 3022 Woodland Ave.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY DISTRESS</u> <u>2396</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral edema</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>BRAIN TUMOR</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION <u>1-7-82</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>BRAIN TUMOR</u>		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M.</u> <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>12-28</u> , 19 <u>81</u> , to <u>1-14</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>1-14</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Louis Solomon</u> MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>1.14.82</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Louis Solomon MD</u>				22e. ADDRESS <u>University Hospital</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>1/20/82</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Westview Mem. Pk.</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Baltimore Co. MD</u>	
24. FUNERAL DIRECTOR NAME <u>Wm. C. March F/H 1101 E. North Ave.</u>				25a. DATE REC'D. BY REGISTRAR <u>JAN 18 1982</u>			
				25b. REGISTRAR'S SIGNATURE <u>James J. Hester</u>			



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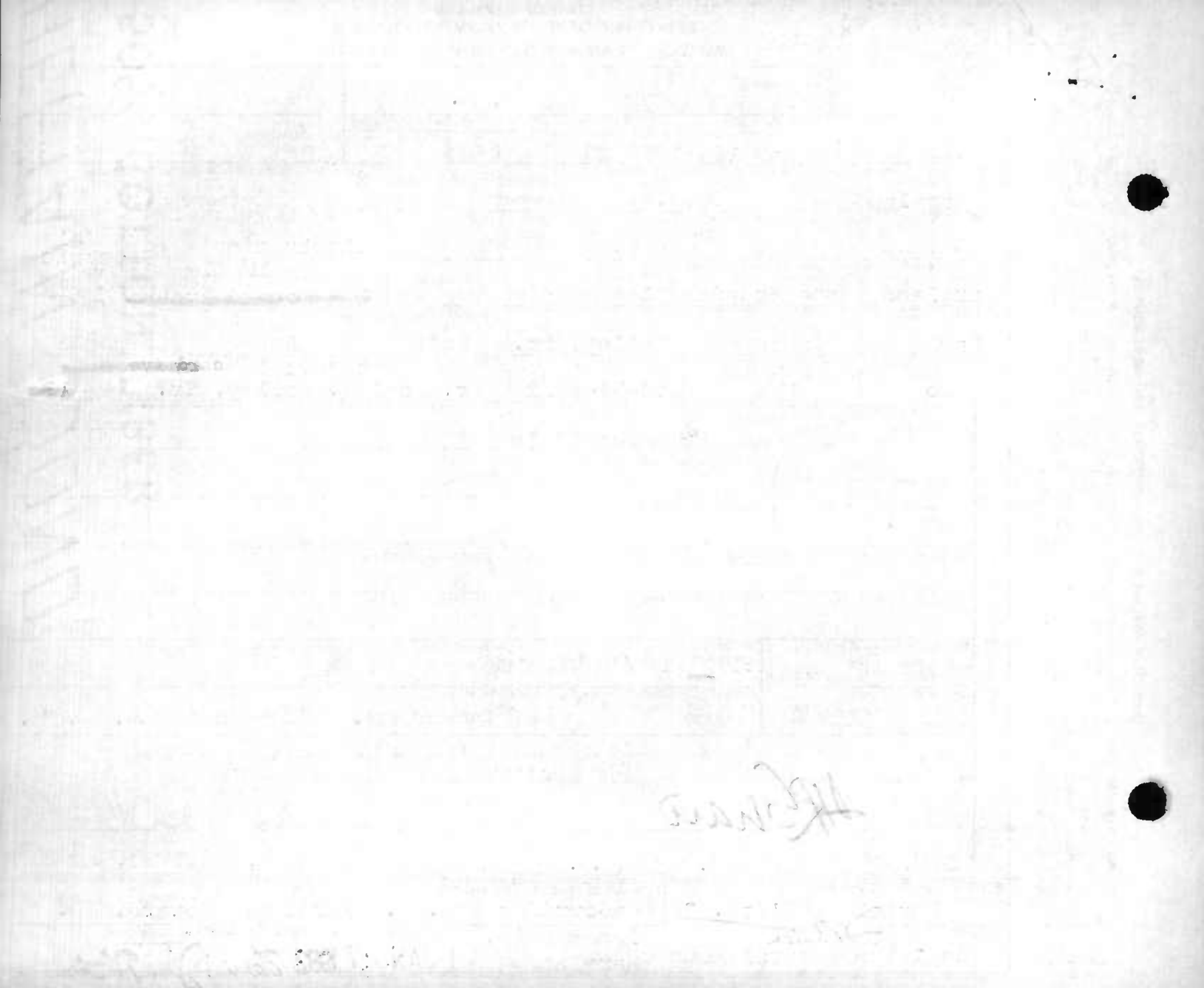


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS ENCOUNTERED, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										REG. NO. 2 0 1 1 5 5	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT) <b>Paul James Kelley, Jr.</b>						2b. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>1 3 19 82</b>		2d. HOUR <b>M</b>			
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 19, 1958</b>		6. AGE (IN YEARS) (LAST BIRTHDAY) MONTHS DAYS HOURS MIN. <b>23 YRS</b>		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>1 3 19 82</b>		2d. HOUR <b>9:35A</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University Hospital (MIEM)</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Electrician</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Arundel Electric</b>			
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Anne Arundel</b>		13c. CITY OR TOWN <b>Glen Burnie</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>114 Glendale Ave. Glenburnie, Md 21061</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Paul James Kelley, Sr.</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lois Ann Campbell</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>N/A</b>		17. INFORMANT (Father) <b>Mr. Paul J. Kelley, Sr. Glenburnie, Md</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Blunt force injury of head</b> DUE TO, OR AS A CONSEQUENCE OF Canditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>2:10 1/3 19 82</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Unknown</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Home</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>108 Packard Ave. Glen Burnie A.A. Co. Md.</b>					
22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> inspection <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> .											
ACTUAL SIGNATURE <b>AR Shaw</b>				TITLE (SPECIFY) <b>Assistant</b>				DATE SIGNED <b>1/4/82</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Hormez R. Guard, M.D.</b>				ADDRESS <b>111 Penn Street, Baltimore, MD 21201</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>17 Jan. 82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem.Pk.</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Elkridge, Howard, MD.</b>	
24. FUNERAL DIRECTOR NAME <b>Singleton Funeral Home</b>				ADDRESS <b>Glen Burnie, Maryland</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 7 1982</b>		25b. REGISTRAR'S SIGNATURE <b>Hormez R. Guard</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 1 5 6

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
JOSEPH ANTHONY KELLY		MONTH DAY YEAR HOUR	
3. SEX		4. RACE	
MALE		WHITE	
5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
MONTH DAY YEAR		IF UNDER 1 YEAR IF UNDER 24 HRS	
08 19 34		47 YRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	
MARYLAND		U.S.A.	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
BALTIMORE CITY		BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	
BALTIMORE		ST. AGNES HOSPITAL	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
OFFICE MANAGER		TRANSOCEANIC	
13a. STATE		13b. COUNTY	
MARYLAND		BALTIMORE	
13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
LANSLOWNE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME	
FIRST MIDDLE LAST		FIRST MIDDLE LAST	
MARCUS M. KELLY		RUTH C. STAMM	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
NO		216-30-9099	
17. INFORMANT		ADDRESS	
JOAN G. KELLY		2215 SMITH AVENUE, 21227	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a) <i>Septic Peritonitis</i>			
DUE TO, OR AS A CONSEQUENCE OF			
(b) <i>Hepatic - Renal failure.</i>			
DUE TO, OR AS A CONSEQUENCE OF			
(c) <i>Acute circulatory failure</i>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)			
<i>Hepato renal failure jaundice.</i>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
1/6/82		9. Rupture viscera	
20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR	
		P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED	
		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/22, 1981, to 1/7/82, that (I) (we) last saw the deceased alive on 1/7/82, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE	
22c. DEGREE		22d. DATE SIGNED	
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		1/7/82	
22e. PHYSICIAN'S NAME (TYPE OR PRINT)		22f. ADDRESS	
DR. NANAVATI		St Agnes Hospital	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
BURIAL		01-11-82	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
MEADOWRIDGE MEM. PK.		ELKRIDGE HOWARD MARYLAND	
24. FUNERAL DIRECTOR NAME ADDRESS		25a. DATE REC'D. BY REGISTRAR	
HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.		JAN 11 1982	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 82 01157			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME FIRST MIDDLE LAST Marty Austin Keys				2b. HOUR 7 A.M.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 8 56		6. AGE (IN YEARS LAST BIRTHDAY) 25 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Balt		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University of Md Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland				13b. COUNTY Cecil		13c. CITY OR TOWN Conowingo	
14. FATHER'S NAME FIRST MIDDLE LAST Vernon D Keys				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dorothy McCaslin			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 212-70-2430			
17. INFORMANT Vernon D. Keys, 11h2 Doctor Jack Rd., Conowingo, Maryland 21918				ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UGI bleed 5715 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) Cirrhosis, cryptogenic DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days months-years							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Multiple Sclerosis							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from November 81 to January 8 82, that (I) lost the deceased alive on January 7 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Lawrence Goldkind MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/8/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lawrence Goldkind MD				22e. ADDRESS 22 S. Grepe St.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12 Jan. 82		23c. NAME OF CEMETERY OR CREMATORY West Nottingham Pres. Rising Sun Cecil Maryland		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Tarring Funeral Home, P.A., Aberdeen, Md. 21001-3399				25a. TIME OF RECORD BY REGISTRAR JAN 12 1982			





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DHMH - 16 50M 1/81  
(VRA 15, 4)

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 1 5 8  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>RUBY JANE KIMBER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JANUARY 6, 1982</b>		2b. HOUR <b>5:00PM</b>
3. SEX <b>Female</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>7 4 40</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>41</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Gastonia, N.C.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>JOHNS HOPKINS HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>MD</b>		13b. COUNTY <b>Baltimore</b>	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>2238 E. Biddle St.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>James Kennedy</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Trula Wallace</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>243-58-9864</b>	17. INFORMANT ADDRESS <b>Anthony E. Kimber 2238 E. Biddle St.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Brain Death</b> <b>5:00 P 1/6/82</b> <b>4300</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Intracerebral Hemorrhage</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Intracranial Aneurysm</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>none</b>					
19a. DATE OF OPERATION <b>1/3/82</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Hemorrhage</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, RAILROAD, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>1/4</b> 19 <b>82</b> , to <b>1/6</b> 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>1/6</b> 19 <b>82</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Noel Tolpin</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>1/6/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Noel Tolpin</b>		22e. ADDRESS <b>Johns Hopkins</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>1/11/82</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Church Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Gastonia NC</b>	
24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H, Inc.</b>			1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR <b>JAN 8 1982</b>

REGISTRAR'S SIGNATURE  
**Theresa J. [Signature]**



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

Released for approval by the Medical Examiner.

MEDICAL CERTIFICATION

Items 22a. Film#G565

1. FOR STATE REGISTRAR 3-1-82 AL

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 8 2 0 1 1 5 9

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CAROLINE K. KING			2a. DATE OF DEATH MONTH DAY YEAR 1 / 18 82		2b. HOUR 6:19 PM
3 SEX Female	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR Sept. 15, 1915	6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10 CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore City Hospitals		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Decorating		12b. KIND OF BUSINESS OR INDUSTRY Interior
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 100 W. Cold Spring Lane
14 FATHER'S NAME FIRST MIDDLE LAST Jay Kindig		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Caroline Skinner			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 057 12 5644	17 INFORMANT ADDRESS Mrs. Caroline F. Bent, Easton, Md. P.O. Box 296			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Massive Burns</u> 8913 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hrs
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ~6 P.M. 1 18 82	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) Smoking in bed			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) Home	21f. LOCATION STREET CITY OR TOWN COUNTY STATE Cold Spring Lane Balt. MD			
22a. I certify that (I) (this hospital) attended the deceased from 1/18 1982 to 1/18 1982, that (I) (we) lost saw the deceased alive on 1/18 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.) Accident					
22b. SIGNATURE [Signature] M.D.		22c. DATE SIGNED 1/18/82		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Welson		22f. ADDRESS Balt City Hosp			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 1/21/82	23c. NAME OF CEMETERY OR CREMATORY Druid Ridge	23d. LOCATION CITY OR TOWN COUNTY STATE Pikesville, Maryland	23e. DATE REC'D. BY REGISTRAR JAN 21 1982	
24 FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. ADDRESS 4905 York Road Balto., Md. 21212		25. DATE REC'D. BY REGISTRAR JAN 21 1982			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 1 6 0

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Charles J. Klein			2a. DATE OF DEATH MONTH DAY YEAR January 14, 1982			2b. HOUR M					
3 SEX male		4 RACE white		5 DATE OF BIRTH MONTH DAY YEAR Sept. 02, 1910		6 AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		7 IF UNDER 1 YEAR MONTHS DAYS		8 IF UNDER 24 HRS HOURS MIN.	
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		9b. CITIZEN OF WHAT COUNTRY? U.S.A.		10 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10 CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) sales-retired		12b. KIND OF BUSINESS OR INDUSTRY hardware			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Halethorpe		13e. STREET ADDRESS 1015 Francis Avenue					
14. FATHER'S NAME FIRST MIDDLE LAST Charles C. Klein				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Von Schlick							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-10-5493		17 INFORMANT ADDRESS Mrs. Beatrice Klein 1015 Francis Avenue							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): 4100 DUE TO, OR AS A CONSEQUENCE OF (b): Coronary occlusion DUE TO, OR AS A CONSEQUENCE OF (c):										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from April 3, 1950, to Jan 14, 1982, that (1) (we) lost saw the deceased alive on June 23, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did not) view the body after death.											
22b. SIGNATURE A. Bradley Daugherty MD						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/14/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. A. Bradley Daugherty MD						22e. ADDRESS 1264 Francis Avenue 21227					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1/18/82		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City Maryland			
24 FUNERAL DIRECTOR NAME Ambrose Funeral Home						ADDRESS 1328 Sulphur Spring Rd.		25a. RECEIVED BY REGISTRAR JAN 19 1982			
								25b. REGISTRAR'S SIGNATURE Frances San Nathan			



*[Faint, illegible handwritten text, possibly a list or ledger entries.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 2 0 1 1 6 1							
1- FOR STATE REGISTRAR		CERTIFICATE OF DEATH								REG. NO.							
1 DECEASED NAME (TYPE OR PRINT)		FIRST JAMES		MIDDLE A		LAST KLOIBER		2a DATE OF DEATH		MONTH 01		DAY 01		YEAR 82		2b HOUR 5:25P	
3 SEX M		4 RACE W		5 DATE OF BIRTH 08 24 08		6 AGE (IN YEARS LAST BIRTHDAY) 73		7a IF UNDER 1 YEAR MONTHS DAYS		7b IF UNDER 24 HRS. HOURS MIN.							
2a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City											
10 CITY OR TOWN OF DEATH Baltimore		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Insurance		12b KIND OF BUSINESS OR INDUSTRY Retired											
13a STATE Md		13b COUNTY BALTO		13c CITY OR TOWN Baltimore		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 1201 Maiden Choice Lane									
14 FATHER'S NAME FIRST Louis		MIDDLE		LAST Kloiber		15 MOTHER'S MAIDEN NAME FIRST Josephine		MIDDLE Burke		LAST							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-09-0927		17 INFORMANT James J. Kloiber		18 ADDRESS 402 Wrenleigh Drive Balto. Md. 21228											
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>METASTATIC Lung Cancer.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Primary Lung Cancer.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED						20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE													
22a I certify that (I) (this hospital) attended the deceased from <u>1/1/82</u> to <u>1/1/82</u> , that (I) (we) lost saw the deceased alive on <u>1/1/82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, so state.)																	
22b SIGNATURE <u>Dr. Machado</u>		DEGREE		22c DATE SIGNED 1/1/82													
22d PHYSICIAN'S NAME (TYPE OR PRINT) DR. MACHADO		22e ADDRESS ST. AGNES HOSP. BALTO. MD.															
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 1/4/82		23c NAME OF CEMETERY OR CREMATORY Most Holy Redeemer		23d LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland											
24 FUNERAL DIRECTOR NAME Witzke, P.A.		ADDRESS 1630 Edmondson Avenue Catonsville, Md. 21228		25a DATE REC'D. BY REGISTRAR JAN 4 1982		25b REGISTRAR'S SIGNATURE <u>Charles J. North</u>											



BP \_\_\_\_\_  
DHMH - 16 50M / 1  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
1. FOR STATE REGISTRAR			REG. NO. 8 2 0 1 1 6 2										
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			MONTH		DAY		YEAR		2b. HOUR	
JOHN GEORGE KLUG, SR.			January		- 17 -		82				M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
male		White		Nov. 16 27		54 YRS.		MONTHS		DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland		U.S.A.				Baltimore City MD							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Baltimore		St. Agnes Hospital				Produce Mgr.		Self-Employed					
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS				
Md.			Anne Arundel		Pasadena		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		8149 Waterfrd. Rd.				
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME										
William V. Klug			Elsie Clauss										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT (Wife)		ADDRESS		Same as # 13				
No			N/A		219.30.3554		Mrs. Susan Marie Klug						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE PULMONARY EDEMA</u> 4219 DUE TO, OR AS A CONSEQUENCE OF (b) <u>MYOCARDITIS, ACUTE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) <u>ENDOCARDITIS, ACUTE</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED				
Michael E. Pelczar			MD						1/18/82				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS										
Michael E. Pelczar, M.D.			St. Agnes Hospital 900 S. Caton Ave.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE						
Burial			21 Jan 82		Glen Haven Mem.Pk.		Glen Burnie, A.A., MD.						
24. FUNERAL DIRECTOR NAME			ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE						
Singleton Funeral Home			Maryland		Glen Burnie, Maryland		JAN 21 1982 James J. Nathan						

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AND 1985

Michael H. Johnson, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/73  
(VRA 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Russell L. Knight, SR.</b>			2a. DATE OF DEATH MONTH <b>1</b> DAY <b>12</b> YEAR <b>82</b>			2b. HOUR M			
3. SEX <b>male</b>		4. RACE <b>NEGRO</b>		5. DATE OF BIRTH MONTH <b>SEPT.</b> DAY <b>1</b> YEAR <b>1919</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE</b> MD.			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1228 N. SPRING ST.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>ARMCO STEEL</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>M.D.</b>		13b. COUNTY		13c. CITY OR TOWN <b>BALTO.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1228 N. SPRING ST.</b>	
14. FATHER'S NAME FIRST <b>HENRY</b> MIDDLE LAST <b>Knight</b>				15. MOTHER'S MAIDEN NAME FIRST <b>ALMA</b> MIDDLE LAST <b>Love</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>				16b. SOCIAL SECURITY NO. <b>1944-46 212-16-3734</b>		17. INFORMANT ADDRESS <b>CATHERINE KNIGHT 1228 N. SPRING ST.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4280 Congestive Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>6/80</b> , to <b>1</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>12</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) give the body after death.									
22b. SIGNATURE <b>Richard Ambinder</b>						DEGREE <b>MD</b>		22c. DATE SIGNED <b>1/16/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Richard Ambinder</b>						22e. ADDRESS <b>Johns Hopkins Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL SPECIFY <b>BURIAL</b>			23b. DATE <b>1/18/1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Crownsville Vet</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Crownsville M.D.</b>		
24. FUNERAL DIRECTOR NAME <b>REDD FUNERAL HOME</b> ADDRESS <b>5209 YORK RD.</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 20 1982</b>		25b. REGISTRAR'S SIGNATURE <b>James J. Martin</b>	

MEDICAL CERTIFICATION

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 2 0 1 1 6 4	
1. DECEASED NAME (TYPE OR PRINT) <b>SONIA RENE KNOX</b>						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>1-7-82</b>		2b. HOUR M <b>9:02</b>			
3. SEX <b>female</b>	4. RACE <b>black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>4 14 54</b>	6. AGE (IN YEARS) LAST BIRTHDAY YRS. <b>27</b>	IF UNDER 1 YR. MONTHS DAYS HOURS MIN'	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD <b>1-7-82</b>		2d. HOUR M <b>9:02</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Parking lot 5603 Pulaski Hgwy.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>MD</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2109 Barclay St.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Donald M. Knox</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Esther O. Stokes</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>N/A</b>		17. INFORMANT ADDRESS <b>Esther Knox 2109 Barclay St.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>9654 IMMEDIATE CAUSE (a) Gunshot wounds of head and chest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR MIN MONTH DAY YEAR <b>8:55 PM 1-7-82</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>subject shot</b>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>parking lot of</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>5603 Pulaski Hgwy. Baltimore, Maryland</b>							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Margareta A. Koroll</b>		TITLE (SPECIFY) M.D. <b>Assistant</b> MEDICAL EXAMINER						DATE SIGNED <b>1-8-82</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Koroll, M.D.</b>		ADDRESS <b>411 Penn Street</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/12/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>King Memorial Pk.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Co. Maryland</b>					
24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H</b>		ADDRESS <b>1101 E. North Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 11 1982</b>							
				25b. REGISTRAR'S SIGNATURE <b>James Jean Nathan</b>							

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COLLIER BROTHERS

NEW YORK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

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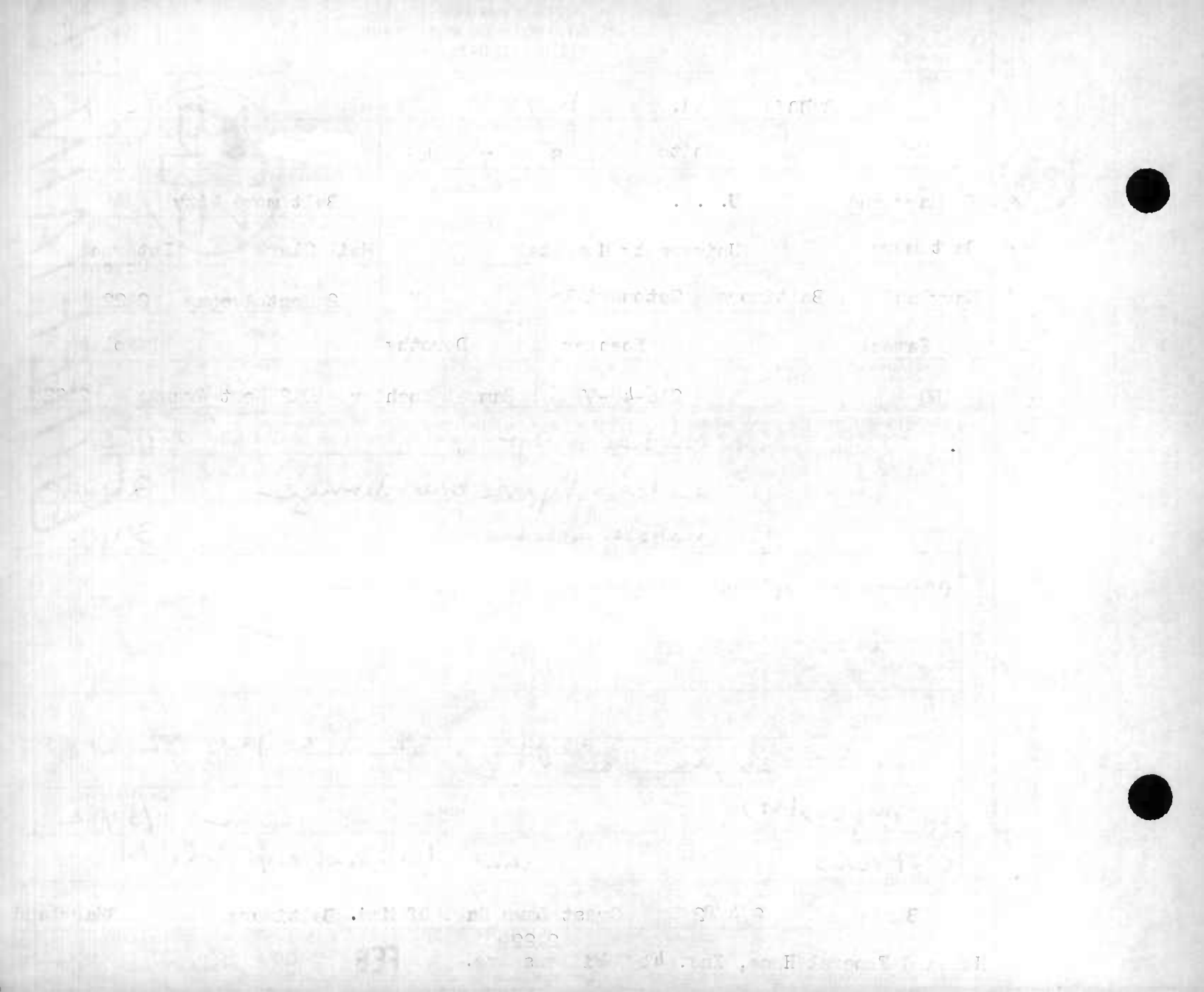
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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 1 6 5

REG. NO.

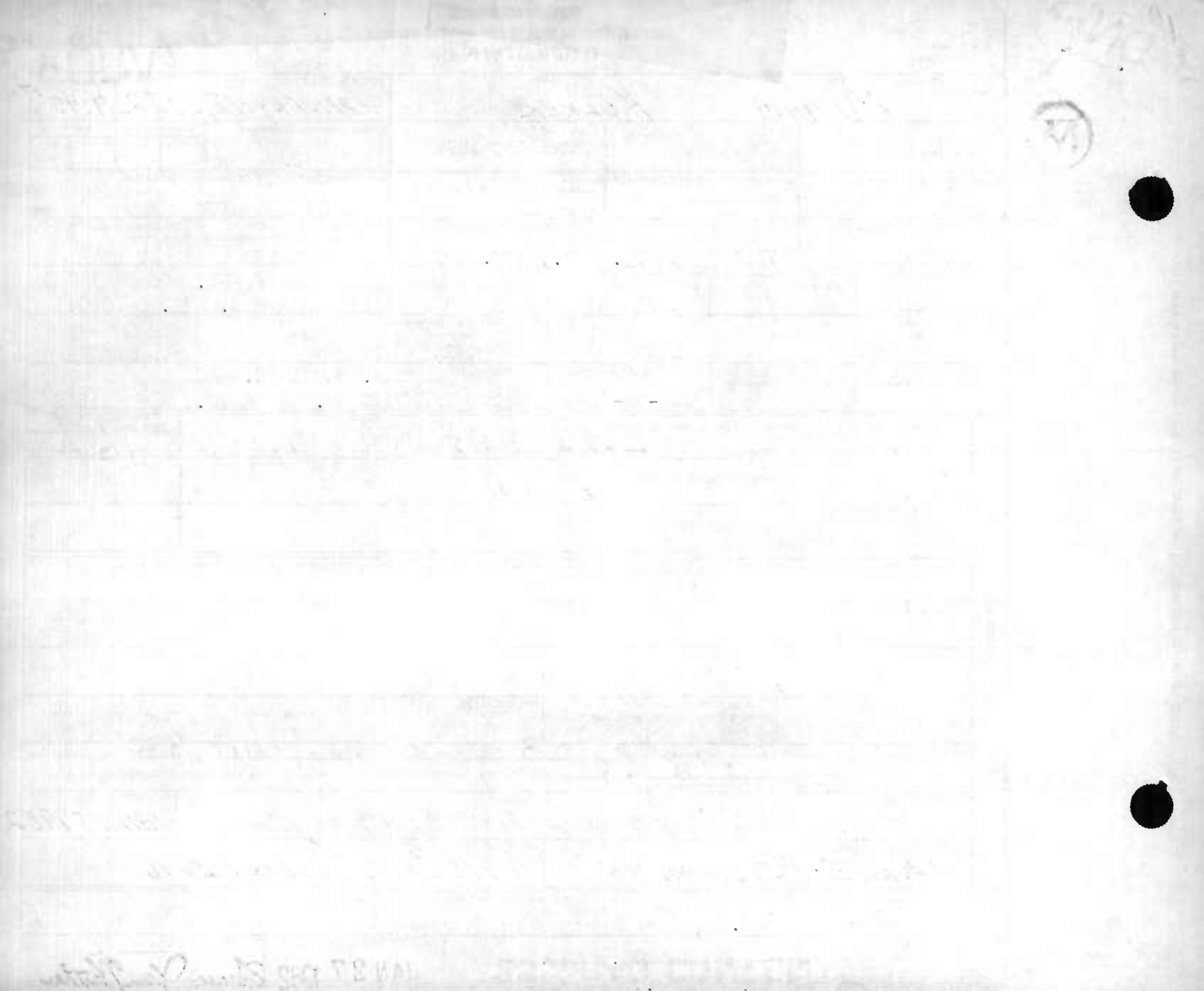
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
BOBBY H. KOEHLER			1 30 82			11 <sup>21</sup> P.M.		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
Male	White	8 MONTH 7 DAY 46 YEAR	35 YRS.			MONTHS DAYS HOURS MIN.		
8. BIRTH PLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland	U.S.A.					Baltimore City MD.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		University Hospital		Mail Clerk			Internal Revenue	
13a. STATE		13b. CITY OR TOWN	13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS		
Maryland		Baltimore	Catonsville YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			1012 Kent Avenue 21228		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST Samuel Koehler			FIRST MIDDLE LAST Dorothy Poling					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
NO			216-48-9756			Samuel Koehler 1012 Kent Avenue 21228		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY:								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) cardiac arrest								4/min.
2501 DUE TO, OR AS A CONSEQUENCE OF (b) acidosis, hypoxic brain damage								2 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) diabetes mellitus								3 days.
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: pneumonia, sp respiratory arrest, renal failure								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
			P.M. 19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 23 Jan 1982, to 30 Jan 1982, that (I) (we) last saw the deceased alive on 23 Jan 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE			DEGREE			22c. DATE SIGNED		
W. Myerks						1/30/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS					
W. MYERKS			Univ of Maryland Hosp, Balt., Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY		
Burial			2/4/82			Crest Lawn Gar. Of Mem. Baltimore		
24. FUNERAL DIRECTOR NAME			24b. ADDRESS			25a. DATE REC'D. BY REGISTRAR		
Hubbard Funeral Home, Inc.			4107 Wilkens Ave. 21229			FEB 3 1982		
						25b. REGISTRAR'S SIGNATURE		
						Ramon J. North		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 300-3500.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 1 1 6 6			
1 - STATE REGISTRAR										REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) <b>MIRIAM</b> <b>KOLKER</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>JANUARY 18, 1982</b>				2b. HOUR MIN. <b>9:45</b> <b>A.</b>				
3 SEX <b>FEMALE</b>		4 RACE <b>WHITE</b>		5. DATE OF BIRTH <b>JUNE 13, 1892</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>89</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>LUDSK</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.							
10 CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>7111 PARK HTS., AVE., APT. 605</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>APT. 605</b> <b>7111 PARK HTS., AVE. #21215</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>ABRAHAM</b> <b>ALTER</b>					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ROSA</b> <b>GOLDBERG</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO <b>220-46-3148</b>		17 INFORMANT <b>MRS. GLORIA K. HACK</b> <b>6810 WESTBROOK RD. BALTO., MD 21215</b>							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>acute myocardial infarction</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>ASCD</b> DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>none</b>													
19a. DATE OF OPERATION <b>nr</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>nr</b> <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <b>8/18/82</b> to <b>1/18/82</b> , that (I) (we) lost saw the deceased alive on <b>8/18/82</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>Maurice Feldman Jr. MD</b>					DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>JAN. 18, 1982</b>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MAURICE FELDMAN JR.</b>					22e. ADDRESS <b>6610 CROSS COUNTRY BLVD.</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>JAN. 20, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CHIZUK AMUNO (ARLINGTON)</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>							
24 FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b>					25a. DATE REC'D. BY REGISTRAR <b>JAN 27 1982</b>								
6010 REGISTERSTOWN RD. BALTO., MD 21215					25b. REGISTRAR'S SIGNATURE <b>James Van Notten</b>								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 1 1 6 7	
1 - FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) <b>CATHERINE M. KOSTENS.</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>01-21-82</b>			2b. HOUR <b>11A</b> M			
3 SEX <b>F.</b>		4 RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3 10 85</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>96</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (COUNTRY) <b>Balto. County</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.					
10. CITY OR TOWN OF DEATH <b>Balto. Md.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Good Samaritan Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Home Maker</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Md.</b>		13b. COUNTY		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>4204 1/2 Mary Avenue -21206</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Conrad Wurzbacher</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary M. Seidel</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES; NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>218-03-9442</b>		17. INFORMANT ADDRESS <b>Gordon W. Kostens - 820 Sacrelett Dr. 21204</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>cardiovascular collapse</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>CHF, Arterio stenosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>chronic renal failure</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (c)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>1/21/82</b> , 19 <b>82</b> , to <b>1/21/82</b> , 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>1/21/82</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>B. Magpal</b>			DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1/21/82</b>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>B. MAGPAL</b>			22e. ADDRESS								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>1-25-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Immanuel Luth. Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. Md.</b>				
24. FUNERAL DIRECTOR NAME <b>John C. Miller Inc-6415 Belair Rd.-21206</b>			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <b>JAN 22 1982 [Signature]</b>						

1. Introduction

2. Objectives

3. Methodology

4. Results

5. Discussion

6. Conclusion

7. References

8. Appendix

9. Acknowledgements

10. Glossary

11. Index



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DRAIN IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

FOR STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE										MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.																																																											
1. DECEASED NAME (TYPE OR PRINT)										FIRST MIDDLE LAST										2a. DATE KNOWN OF DEATH										MONTH DAY YEAR										2b. HOUR																																																	
Douglas Joseph Kouneski																				1 4 19 82										M																																																											
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (IN YEARS)										IF UNDER 1 YR.										IF UNDER 24 HRS.										7c. DATE PRONOUNCED DEAD										MONTH DAY YEAR										7d. HOUR									
male										white										Feb 22 1961										20 YRS.																																								1 4 19 82										7:14A									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH																				MD.																																							
Md.										U.S.A.																				Baltimore City																																																											
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)										12b. KIND OF BUSINESS OR INDUSTRY																																																											
Baltimore										4311 Mary Avenue										Carpet Installer										-																																																											
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13a. CITY OR TOWN										13d. INSIDE CITY LIMITS?										13e. STREET ADDRESS																																																											
13a. STATE										13b. COUNTY										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										4311 Mary Ave.																																																											
Md.										Baltimore																																																																															
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME																																																																															
FIRST MIDDLE LAST										FIRST MIDDLE LAST																																																																															
Dominick Kouneski										Mary King																																																																															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)										16b. SOCIAL SECURITY NO.										17. INFORMANT										ADDRESS										same address																																																	
no										213-78-7581										Mary Kouneski (mother)																																																																					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																																															
PART 1 DEATH WAS CAUSED BY:																																																																																									
IMMEDIATE CAUSE (a) Hanging																																																																																									
9530										DUE TO, OR AS A CONSEQUENCE OF																																																																															
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.										(b)										DUE TO, OR AS A CONSEQUENCE OF																																																																					
										(c)																																																																															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT BELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																																																																																									
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?										YES <input type="checkbox"/> NO <input type="checkbox"/>																																																											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY approx. 7:00AM 1/4 1982										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										found hanging by neck																																																											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)										21f. LOCATION										CITY OR TOWN										COUNTY										STATE																																							
										home										4311 Mary Avenue, Baltimore,										MD																																																											
22a. I certify that I took charge of the remains described above, held on death resulted from										Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																																																																															
Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																																																																																									
ACTUAL SIGNATURE										TITLE (SPECIFY)										DATE SIGNED										1/4/82																																																											
H.R. Shaw										M.D. Assistant										MEDICAL EXAMINER																																																																					
EXAMINER'S NAME (TYPE OR PRINT)										ADDRESS																																																																															
Hormez R. Guard, M.D.,										111 Penn Street, Baltimore, MD 21201																																																																															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION										CITY OR TOWN										COUNTY										STATE																													
Burial										1/6/82										Moreland Mem. Pk.										Baltimore																				Md.																																							
24. FUNERAL DIRECTOR										25a. DATE REC'D. BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																																																																					
Schimunek Funeral Home, Inc.										JAN 5 1982										James J. Nathan																																																																					
3331 Brehms Lane, Balto. Md. 21213																																																																																									

Wm. B. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

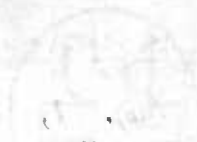
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 1 6 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Elizabeth F Kowalewski			2a. DATE OF DEATH MONTH DAY YEAR 1-14-82			2b. HOUR 11 35 A.M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 1, 1915		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 503 Freeman St. 21225	
14. FATHER'S NAME FIRST MIDDLE LAST Augustine Linderman				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose Rhodes					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 217-12-8993 A		17. INFORMANT ADDRESS Joseph Kowalewski, same as 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u> <u>2028</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Non Hodgkins lymphoma</u> 5 yrs DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Diabetes melitus, Hypertension</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Howard Freeland MD						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1-14-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Howard Freeland MD						22e. ADDRESS University Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1/18/1982		23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn Pk. Anne Arundel, Md.		
24. FUNERAL DIRECTOR NAME Mc Cully F.H. Mountain & Tick						ADDRESS Pasadena Md. Neck Rds. 21122		25a. DATE REC'D. BY REGISTRAR JAN 19 1982	
25b. REGISTRAR'S SIGNATURE Thom J. [Signature]									

THE UNIVERSITY OF CHICAGO



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 1 1 7 0	
FOR 1 - STATE REGISTRAR		REG. NO.									
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Paul P. Kowanic</b>						2a DATE OF DEATH MONTH DAY YEAR <b>January 20 1982</b>		Approx <b>5:00 P.M.</b>			
3 SEX <b>Male</b>		4 RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 5 1915</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>66</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Penna.</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore City Hospital</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Agent</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Ins. Co.</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a STATE <b>Md.</b>		13b. COUNTY		13c CITY OR TOWN <b>Baltimore</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>4012 Southern Ave.</b>			
14 FATHER'S NAME FIRST MIDDLE LAST <b>John Kowanic</b>					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Susan Misenko</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>220-07-4907</b>		17 INFORMANT ADDRESS <b>Wilma Kowanic (wife) same address</b>							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b> (c) <b>Bilateral carotid arterial stenosis</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>17 years</b> <b>4 years</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) <del>XXXXXX</del> attended the deceased from <b>April 25, 1963</b> to <b>Sept 16, 1981</b> , that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on <b>Sept 16, 1981</b> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did not) view the body after death.											
22b. SIGNATURE <b>S. J. Liu M.D.</b>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1/21/82</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>S. J. LIU, M. D.</b>						22e. ADDRESS <b>1900 E. Northern Parkway Balto Md 21239</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/25/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. Md.</b>					
24 FUNERAL DIRECTOR <b>Schimmek Funeral Home, Inc.</b> <b>3331 Brehms Lane, Balto. Md. 21213</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN-22 1982</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

APR 22 2:00 P

Subson  
17 years  
4 years  
Acute myocardial infarction  
Arteriosclerotic cardiovascular disease  
Bilateral carotid arterial stenosis

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April 22, 2000

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1/21/02

1900 E. Northern Parkway, Suite 2123

2. J. L. H. O.

APR 22 2000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 24 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 336-1335.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 1 7 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
BERNARD		KREUTZER		01 14 82		A M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
MALE	WHITE	06 08 13		68 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
MARYLAND	U.S.A.			BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE	103 N. MONROE STREET			TELEVISION RE-		SELF-EMPLOYED	
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS		
MARYLAND		---	BALTIMORE	YES	103 N. MONROE STREET		
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		17. INFORMANT ADDRESS			
CARLTON		KRUEZTER		GOLDIE ESPENSHIED			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
NO		218-18-1918		CATHERINE PICKING 405 S. AUGUSTA AVENUE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 POSSIBLE Arrhythmia							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) possible acute coronary attack.							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE DEGREE				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
ROLENDO M. SABUNDAYO, M.D.				1940 W. BALTIMORE STREET			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
BURIAL		01-18-82		FORT LINCOLN		Silver Spring Montgomery Md.	
24. FUNERAL DIRECTOR NAME ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.		21229		JAN 18 1982		Francis J. Kistner	



TO: [illegible]  
FROM: [illegible]  
SUBJECT: [illegible]  
[illegible text follows]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR										
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>WALTER HARRY KREY J.R.</u>					2a. DATE OF DEATH MONTH DAY YEAR <u>1 10 82</u>					
3. SEX <u>M</u>		4. RACE <u>W</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>6 28 22</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>59</u> YRS.		2b. HOUR <u>12:45 M</u>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Pittsburgh PA.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>BALTO. CITY</u> MD.				
10. CITY OR TOWN OF DEATH <u>BALTO.</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>MERCY HOSPITAL</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>ENGINEER</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Public Health</u>		
13a. STATE <u>Md.</u>			13b. COUNTY <u>—</u>		13c. CITY OR TOWN <u>BALTO.</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <u>817 St. Paul Pl</u>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>WALTER H. KREY SR.</u>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>ANNA Kitzmann</u>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>yes</u>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>WW II</u>		17. INFORMANT <u>Margaret O. Krey</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MASSIVE GI. Bleed</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CIRRHOSIS, PORTAL Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Esophageal Varices, Pneumonia</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Chronic lung disease</u>										
19a. DATE OF OPERATION <u>—</u>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>—</u> P.M. <u>19</u>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <u>—</u>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <u>—</u>			21f. LOCATION STREET CITY OR TOWN COUNTY STATE <u>—</u>				
22a. I certify that (I) (this hospital) attended the deceased from <u>12/31</u> , 19 <u>81</u> , to <u>1/10/82</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>1/10</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Stephen D. Campbell, MD</u>					DEGREE <u>MD</u>		22c. DATE SIGNED <u>1/11/82</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Stephen D. Campbell</u>					22e. ADDRESS <u>Mercy Hospital Balto, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL <u>Burial</u>			23b. DATE <u>1-14-82</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Westminster Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Westminster Carroll Md.</u>			
24. FUNERAL DIRECTOR <u>Fletcher Funeral Home</u>					25a. DATE REC'D. BY REGISTRAR <u>JAN 10 1982</u>					
25b. REGISTRAR'S SIGNATURE <u>Anna J. [Signature]</u>										



RECEIVED OCT 10 1904

*[Faint, illegible handwriting on lined paper, possibly bleed-through from the reverse side.]*

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 1 7 3

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>GEORGETTE KRIEGER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JANUARY 26, 1982</b>		2b. HOUR <b>9:30 A.M.</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>FEB. 28 1999</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN) <b>France</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Church Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK OR LAST WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>-</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Almond Percot</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Leticia Jolly</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>001 14 4900</b>		17. INFORMANT ADDRESS <b>Blanche Malinowski, Sister 656 48th St. Balto., Md. 21224</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY FAILURE</b> <b>2352</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>VILLOUS ADENOMA OF RECTUM WITH DEHYDRATION</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>JANUARY 16</b> 19 <b>82</b> , to <b>JANUARY 26</b> 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>JANUARY 26</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Gopal Guruswamy</i>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1/26/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>GOPAL GURUSWAMY, M.D.</b>		22e. ADDRESS <b>CHURCH HOSPITAL CORPORATION 100 NORTH BROADWAY, BALTIMORE, MD 21231</b>			
23a. BURIAL, CREMATION, REMOVAL (S) <b>Burial</b>		23b. DATE <b>1/29/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>	
23d. LOCATION <b>Baltimore Co., Md.</b>		23e. NAME OF CEMETERY OR CREMATORY <b>Baltimore Co., Md.</b>		23f. LOCATION <b>Baltimore Co., Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Brudzinski Funeral Home</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 27 1982</b>		25b. REGISTRAR'S SIGNATURE <i>Thomas J. ...</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 7 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 1 7 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Robert E. Krouse			2a. DATE OF DEATH January 23, 1982		2b. HOUR 8:55A M	
3. SEX MALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR 12 3 1919		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW JERSEY	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital		12a. OCCUPATION (TYPE OF WORK OR BUSINESS WORKING LIFE) Financing ADM.		12b. KIND OF BUSINESS OR INDUSTRY U.S. GOVERNMENT	
13a. STATE MARYLAND		13b. COUNTY BALTIMORE	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST PAUL KROUSE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CHRISTINE WAGNER				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 149-05-1844		17. INFORMANT ADDRESS CATHERINE KROUSE 3406 MEADOWDALE DRIVE 21207		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of Lung 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from January 6, 1982, to January 23, 1982, that (I) (we) last saw the deceased alive on January 23, 1982, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.						
22b. SIGNATURE Jim-Jer Hwu M.D.		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/23/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jim-Jer Hwu, M.D.		22e. ADDRESS c/o Maryland General Hospital				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 1-25-82		23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE
24. FUNERAL DIRECTOR NAME ADDRESS SOL LEVINSON & BROS. 6010 REISTERSTOWN ROAD				25a. DATE REC'D. BY REGISTRAR JAN 27 1982		

(M)

January 22, 1965

RECEIVED

1965

Washington, D.C.

Director, Federal Bureau of Investigation

January 22, 1965

RECEIVED

January 23, 1965

Director, Federal Bureau of Investigation

Handwritten signature and initials at the bottom left corner.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

RELEASED NON-MED PER DR. A. DIXON

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer-deaths with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO. 8201175					
1. DECEASED NAME (TYPE OR PRINT) DR. CORNELIUS WOLFRAM KRUSE					2a. DATE OF DEATH MONTH DAY YEAR JANUARY 17, 1982					2b. HOUR 2:35AM
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 13, 1913		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Texas		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PROVIDENT HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Professor		12b. KIND OF BUSINESS OR INDUSTRY Johns Hopkins		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Andrew Kruse					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Geraldine Eilts					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220 30 2825		17. INFORMANT Mrs. Adele R. Kruse		ADDRESS 2445 Pickwick Rd.		Same		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4100 Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF: b) <u>Coronary Artery Disease</u> DUE TO, OR AS A CONSEQUENCE OF: c) <u>Hypertensive Cardiovascular Disease</u> APPROPRIATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (this hospital) attended the deceased from <u>April 1980</u> to <u>Jan. 1982</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death.)										
22b. SIGNATURE <u>Glendon E. Rayson, M.D.</u>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <u>Jan 18, 1982</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GLEDON E. RAYSON, M.D.					22e. ADDRESS JOHNS HOPKINS HOSPITAL					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/20/82		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park		23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Md.				
24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. 4905 York Road Balto., Md. 21212					25a. DATE REC'D. BY REGISTRAR JAN 19 1982		25b. REGISTRAR'S SIGNATURE <u>Thomas Jan North</u>			

Join us

Henry W. Johnston, Jr. Co.

1911. 1912. 1913. 1914. 1915. 1916. 1917. 1918. 1919. 1920. 1921. 1922. 1923. 1924. 1925. 1926. 1927. 1928. 1929. 1930. 1931. 1932. 1933. 1934. 1935. 1936. 1937. 1938. 1939. 1940. 1941. 1942. 1943. 1944. 1945. 1946. 1947. 1948. 1949. 1950. 1951. 1952. 1953. 1954. 1955. 1956. 1957. 1958. 1959. 1960. 1961. 1962. 1963. 1964. 1965. 1966. 1967. 1968. 1969. 1970. 1971. 1972. 1973. 1974. 1975. 1976. 1977. 1978. 1979. 1980. 1981. 1982. 1983. 1984. 1985. 1986. 1987. 1988. 1989. 1990. 1991. 1992. 1993. 1994. 1995. 1996. 1997. 1998. 1999. 2000. 2001. 2002. 2003. 2004. 2005. 2006. 2007. 2008. 2009. 2010. 2011. 2012. 2013. 2014. 2015. 2016. 2017. 2018. 2019. 2020. 2021. 2022. 2023. 2024. 2025. 2026. 2027. 2028. 2029. 2030. 2031. 2032. 2033. 2034. 2035. 2036. 2037. 2038. 2039. 2040. 2041. 2042. 2043. 2044. 2045. 2046. 2047. 2048. 2049. 2050. 2051. 2052. 2053. 2054. 2055. 2056. 2057. 2058. 2059. 2060. 2061. 2062. 2063. 2064. 2065. 2066. 2067. 2068. 2069. 2070. 2071. 2072. 2073. 2074. 2075. 2076. 2077. 2078. 2079. 2080. 2081. 2082. 2083. 2084. 2085. 2086. 2087. 2088. 2089. 2090. 2091. 2092. 2093. 2094. 2095. 2096. 2097. 2098. 2099. 2100. 2101. 2102. 2103. 2104. 2105. 2106. 2107. 2108. 2109. 2110. 2111. 2112. 2113. 2114. 2115. 2116. 2117. 2118. 2119. 2120. 2121. 2122. 2123. 2124. 2125. 2126. 2127. 2128. 2129. 2130. 2131. 2132. 2133. 2134. 2135. 2136. 2137. 2138. 2139. 2140. 2141. 2142. 2143. 2144. 2145. 2146. 2147. 2148. 2149. 2150. 2151. 2152. 2153. 2154. 2155. 2156. 2157. 2158. 2159. 2160. 2161. 2162. 2163. 2164. 2165. 2166. 2167. 2168. 2169. 2170. 2171. 2172. 2173. 2174. 2175. 2176. 2177. 2178. 2179. 2180. 2181. 2182. 2183. 2184. 2185. 2186. 2187. 2188. 2189. 2190. 2191. 2192. 2193. 2194. 2195. 2196. 2197. 2198. 2199. 2200. 2201. 2202. 2203. 2204. 2205. 2206. 2207. 2208. 2209. 2210. 2211. 2212. 2213. 2214. 2215. 2216. 2217. 2218. 2219. 2220. 2221. 2222. 2223. 2224. 2225. 2226. 2227. 2228. 2229. 2230. 2231. 2232. 2233. 2234. 2235. 2236. 2237. 2238. 2239. 2240. 2241. 2242. 2243. 2244. 2245. 2246. 2247. 2248. 2249. 2250. 2251. 2252. 2253. 2254. 2255. 2256. 2257. 2258. 2259. 2260. 2261. 2262. 2263. 2264. 2265. 2266. 2267. 2268. 2269. 2270. 2271. 2272. 2273. 2274. 2275. 2276. 2277. 2278. 2279. 2280. 2281. 2282. 2283. 2284. 2285. 2286. 2287. 2288. 2289. 2290. 2291. 2292. 2293. 2294. 2295. 2296. 2297. 2298. 2299. 2300. 2301. 2302. 2303. 2304. 2305. 2306. 2307. 2308. 2309. 2310. 2311. 2312. 2313. 2314. 2315. 2316. 2317. 2318. 2319. 2320. 2321. 2322. 2323. 2324. 2325. 2326. 2327. 2328. 2329. 2330. 2331. 2332. 2333. 2334. 2335. 2336. 2337. 2338. 2339. 2340. 2341. 2342. 2343. 2344. 2345. 2346. 2347. 2348. 2349. 2350. 2351. 2352. 2353. 2354. 2355. 2356. 2357. 2358. 2359. 2360. 2361. 2362. 2363. 2364. 2365. 2366. 2367. 2368. 2369. 2370. 2371. 2372. 2373. 2374. 2375. 2376. 2377. 2378. 2379. 2380. 2381. 2382. 2383. 2384. 2385. 2386. 2387. 2388. 2389. 2390. 2391. 2392. 2393. 2394. 2395. 2396. 2397. 2398. 2399. 2400. 2401. 2402. 2403. 2404. 2405. 2406. 2407. 2408. 2409. 2410. 2411. 2412. 2413. 2414. 2415. 2416. 2417. 2418. 2419. 2420. 2421. 2422. 2423. 2424. 2425. 2426. 2427. 2428. 2429. 2430. 2431. 2432. 2433. 2434. 2435. 2436. 2437. 2438. 2439. 2440. 2441. 2442. 2443. 2444. 2445. 2446. 2447. 2448. 2449. 2450. 2451. 2452. 2453. 2454. 2455. 2456. 2457. 2458. 2459. 2460. 2461. 2462. 2463. 2464. 2465. 2466. 2467. 2468. 2469. 2470. 2471. 2472. 2473. 2474. 2475. 2476. 2477. 2478. 2479. 2480. 2481. 2482. 2483. 2484. 2485. 2486. 2487. 2488. 2489. 2490. 2491. 2492. 2493. 2494. 2495. 2496. 2497. 2498. 2499. 2500. 2501. 2502. 2503. 2504. 2505. 2506. 2507. 2508. 2509. 2510. 2511. 2512. 2513. 2514. 2515. 2516. 2517. 2518. 2519. 2520. 2521. 2522. 2523. 2524. 2525. 2526. 2527. 2528. 2529. 2530. 2531. 2532. 2533. 2534. 2535. 2536. 2537. 2538. 2539. 2540. 2541. 2542. 2543. 2544. 2545. 2546. 2547. 2548. 2549. 2550. 2551. 2552. 2553. 2554. 2555. 2556. 2557. 2558. 2559. 2560. 2561. 2562. 2563. 2564. 2565. 2566. 2567. 2568. 2569. 2570. 2571. 2572. 2573. 2574. 2575. 2576. 2577. 2578. 2579. 2580. 2581. 2582. 2583. 2584. 2585. 2586. 2587. 2588. 2589. 2590. 2591. 2592. 25

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Post 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |   |   |   |   |   |
|--|---|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>John S Kulacki</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>January 28 1982</b>                            |   | 2b. HOUR<br><b>6:08 P.M.</b>                        |
| 3. SEX<br><b>MALE</b>  | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>12 25 01</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b> YRS.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>CITY</b> MD.   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St Agues Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Bookkeeper</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>retired</b> |
| 13a. STATE<br><b>Maryland</b>  |   | 13b. COUNTY   | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |   | 16b. SOCIAL SECURITY NO.<br><b>216-09-6976</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Richard P. Kulacki, 9 Melvin Ave.</b>                            |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Anoxia</b><br><b>4140</b> DUE TO, OR AS A CONSEQUENCE OF <b>ASHD</b><br>(b) <b>years</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Calcific Aortic Stenosis</b><br>(c) <b>years</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) |   |   |   |   |   |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)    |   |   |   |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |   |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>Home</b>   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 19 82</b> to <b>1/28 19 82</b> , that (I) <del>was</del> lost<br>saw the deceased alive on <b>1/28</b> 19 <b>82</b> and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated<br>above, (I) <del>was</del> (did not) view the body after death.   |   |   |   |   |   |
| 22b. SIGNATURE<br><b>James Nolan</b>   |   | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>1/29/82</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>James Nolan</b>  |   | 22e. ADDRESS  |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |   | 23b. DATE<br><b>2/1/82</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Mausoleum</b>                                 |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md</b>  |   | 24. FUNERAL DIRECTOR <b>1630 Edmondson Ave., Catonsville, Md</b><br>NAME ADDRESS<br><b>Witzke Catonsville Funeral Home P.A. 21228</b>                       |   |   |   |
| 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 29 1982</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Thomas J. Nolan</b>  |   |   |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: This certificate requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene proper to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certificate filed.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |  |  | 8 2 0 1 1 7 7 |  |
|--|--|--|--|---|--|---|--|--|--|---------------|--|
| FOR<br>STATE<br>REGISTRAR  |  | REG. NO.   |  |   |  |   |  |  |  |               |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ELIZABETH A. KUMMER</b>  |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JANUARY 24, 1982</b>  |  | 2b. HOUR<br><b>12:50a</b>  |  |               |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Mar. 13, 1931</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>50</b>  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>YRS.</b>   |  |               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.   |  |  |  |               |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Medical Secretary</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |               |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>Harford</b>  |  | 13c. CITY OR TOWN<br><b>Joppa</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>808 Pine Road</b>  |  |               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Patrick Henry Murray</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Margaret C. Hannan</b>  |  |   |  |  |  |               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>213-28-9406</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Mr. Donald H. Kummer same</b>  |  |  |  |               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>GI Bleed</b><br><b>5728</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Hepatic failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>48 hours</b>  |  |               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |   |  |   |  |  |  |               |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |               |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>October 28, 1981</b> to <b>Jan. 24, 1982</b> , that (I) (we) last saw the deceased alive on <b>Jan. 24, 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                |  |  |  |   |  |   |  |  |  |               |  |
| 22b. SIGNATURE<br><b>Patricia A. Savadel, MD</b>   |  |  |  |   |  | DEGREE<br><b>ATTENDING PHYSICIAN</b> <input type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1/24/82</b>   |  |               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>PATRICIA SAVADEL</b>   |  |  |  | 22e. ADDRESS<br><b>JOHNS HOPKINS HOSPITAL</b>   |  |   |  |  |  |               |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>Jan. 27, 1982</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Balto. National</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>  |  |  |  |               |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Leonard J. Ruck Inc. Baltimore, Maryland</b>  |  |  |  |   |  | 25a. DATE RECD. BY REGISTRAR<br><b>JAN 25 1982</b>  |  |  |  |               |  |
|  |  |  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>James J. Nathan</b>  |  |  |  |               |  |

JAN 25 1985  
James J. [Signature]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| 1- FOR STATE REGISTRAR  |  |   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 8 2 0 1 1 7 8<br>REG. NO.  |  |                 |  |
|---|--|---|--|---|--|--|--|--|--|-----------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FRANK KURLAND  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1/19/82  |  |  |  | 2b. HOUR<br>1254 PM  |  |                 |  |
| 3. SEX<br>MALE  |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>07 18 1912  |  | 6. AGE (IN YEARS (LAST BIRTHDAY))<br>69 years  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  | IF UNDER 24 HRS |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>VIRGINIA   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>CITY - BALTIMORE MD                          |  |  |  |                 |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SINAI HOSPITAL |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SALESMAN         |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>PLUMBING  |  |                 |  |
| 13a. STATE<br>MARYLAND  |  | 13b. CITY OR TOWN<br>BALTIMORE  |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13d. STREET ADDRESS<br>4 AMLEHT CT., APT. 2D   |  | SUPPLIES #21215  |  |                 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JACOB KURLAND   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ANNA SCHERR  |  |  |  |  |  |                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO  |  |   |  | 16b. SOCIAL SECURITY #<br>213-09-8312<br>051-10-5558  |  |  |  | 17. INFORMANT<br>MRS. IRENE KURLAND<br>4 AMLEHT CT., APT. 2D #21215  |  |                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION.<br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>30 MINUTES   |  |                 |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>LEFT PLEURAL EFFUSION  |  |   |  |   |  |  |  |  |  |                 |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |                 |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |                 |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/08/82, 19____, to 1/19/82, 19____, that (I) (we) lost saw the deceased glide on 1/19/82, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                      |  |   |  |   |  |  |  |  |  |                 |  |
| 22b. SIGNATURE<br>A. Karim  |  |   |  | DEGREE<br>M-D ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>    |  |  |  | 22c. DATE SIGNED<br>1/19/82  |  |                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>A. KARIM MD.   |  |   |  | 22e. ADDRESS<br>Sinai Hospital, Baltimore Md.   |  |  |  |  |  |                 |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  | 23b. DATE<br>JAN. 20, 1982  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>TIFERETH ISRAEL ANSHE SFARD   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>ROSEDALE BALTO., MD                    |  |  |  |                 |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>SOL LEVINSON & BROS., INC.<br>6010 REISTERSTOWN RD. BALTO., MD 21215  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 27 1982  |  | 25b. REGISTRAR'S SIGNATURE<br>Frances Jan Nathan                                     |  |  |  |                 |  |



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113-90-812

113-90-812

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO. 8-2 01179  |  |   |   |
|--|--|--|--|---|--|---|---|
| 1. FOR STATE REGISTRAR   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |   |   |
| 1. DECEASED NAME FIRST MIDDLE LAST<br>(TYPE OR PRINT) GERTRUDE ADELE KUTZLEB   |  |  |  | January 3, 1982   |  |   |   |
| 3. SEX<br>Female   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>April 2, 1898  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>83 YRS.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.  |   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Long Green Nursing Home |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Accountant  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>U.S. Gov't.  |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Maryland 13b. COUNTY 13c. CITY OR TOWN Baltimore   |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Richard Kutzleb   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Martha Bartels  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No   |  |  |  | 16b. SOCIAL SECURITY NO.  |  |   |   |
| 17. INFORMANT ADDRESS<br>Mrs. William Schultz, Balto., Md.   |  |  |  |   |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CEREBRAL VASCULAR DISEASE<br>8880 DUE TO, OR AS A CONSEQUENCE OF (b)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)<br>MANNER OF DEATH Accident |  |  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>onset |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>FRACTURE - HIP -   |  |  |  |   |  |   |   |
| 19a. DATE OF OPERATION<br>12-06-81   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>FRACTURED HIP  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>? A.M. MONTH DAY YEAR<br>12/6/1981  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br>fell walking in her room  |  |   |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>Nsrhome  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>Long Green Nursing Home, Baltimore City, MD  |  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 31, 1968, to 1/3/82, that (I) saw the deceased alive on 12-27-81, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |   |
| 22b. SIGNATURE<br>Dr. Martin Singewald M.D.  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br>1/4/82  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Martin Singewald, M.D.  |  |  |  | 22e. ADDRESS<br>11 E. Chase Street, Balto., Md.   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>1/5/82  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Lorraine Park   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto., Md.   |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Henry W. Jenkins & Sons Co.<br>4905 York Road Balto., Md. 21212  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 5 1982   |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]   |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

|   |  |  |   |  |  |  |  |  |  |  |  |   |  |  |                               |  |  |
|---|--|--|---|--|--|--|--|--|--|--|--|---|--|--|-------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Celeste</b>  |  |  | FIRST <b>E.</b>   |  |  | MIDDLE <b>Lang</b>   |  |  | LAST   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>1-13-82</b>      |  |  | 2b. HOUR<br><b>11:00 P.M.</b> |  |  |
| 3 SEX<br><b>FEMALE</b>  |  |  | 4 RACE<br><b>WHITE</b>  |  |  | 5 DATE OF BIRTH MONTH DAY YEAR<br><b>10 29 02</b>  |  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> YRS.   |  |  | IF UNDER 1 YEAR MONTHS DAYS                             |  |  | IF UNDER 24 HRS. HOURS MIN.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.   |  |  |   |  |  |                               |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  |  | 11. <del>DECEASED IN HOSPITAL</del> <b>Memorial Home</b><br>11b. US OF ACILITE, USE STREET ADDRESS<br><b>1000 S. Caton Ave. Balt; Md. 21229</b> |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |   |  |  |                               |  |  |
| 13a. STATE<br><b>Maryland</b>   |  |  | 13b. COUNTY<br><b>Baltimore</b>   |  |  | 13c. CITY OR TOWN<br><b>Woodlawn</b>   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |  | 13e. STREET ADDRESS<br><b>2206 Southland Road 21207</b> |  |  |                               |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Edgar</b>   |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Inez Mae Jarboe</b>  |  |  |  |  |  |  |  |  |   |  |  |                               |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>219-30-6844</b>   |  |  | 17 INFORMANT<br><b>Kennard G. Lang, Jr.</b>  |  |  | ADDRESS<br><b>2206 Southland Rd. 21207</b>   |  |  |   |  |  |                               |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br><b>4360</b> IMMEDIATE CAUSE (a) <b>Arteriosclerotic cerebrovascular disease with stroke</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>stroke</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>stroke</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>year</b> |  |  |   |  |  |  |  |  |  |  |  |   |  |  |                               |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |  |  |  |  |  |  |  |  |   |  |  |                               |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |   |  |  |                               |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |  |   |  |  |                               |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |   |  |  |                               |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1-13-82</b> to <b>1-13-82</b> that <del>the</del> (we) last saw the deceased alive on <b>1-13-82</b> , and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>we</del> (we) (did) (did not) view the body after death.                            |  |  |   |  |  |  |  |  |  |  |  |   |  |  |                               |  |  |
| 22b. SIGNATURE<br><b>Laurence Gallager</b>  |  |  | DEGREE<br><b>M.D.</b>   |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                 |  |  | 22c. DATE SIGNED<br><b>1-15-82</b>   |  |  |   |  |  |                               |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>LAURENCE R. GALLAGER, M.D.</b>  |  |  | 22e. ADDRESS<br><b>ST. AGNES MEDICAL CENTER, 21229</b>  |  |  |  |  |  |  |  |  |   |  |  |                               |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  |  | 23b. DATE<br><b>1/16/82</b>   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>WOODLAWN CEMETERY</b>   |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>WOODLAWN BALTIMORE MARYLAND</b>  |  |  |   |  |  |                               |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>HUBBARD FUNERAL HOME, INC.</b>  |  |  | ADDRESS<br><b>4107 WILKINS AVE.</b>   |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 18 1982</b>  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Francis J. Smith</b>  |  |  |   |  |  |                               |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 1 8 1

REG. NO.

|  |   |   |  |  |   |
|--|---|---|--|--|---|
| 1. FOR STATE REGISTRAR   |   | 2a. DATE OF DEATH   |  | 2b. HOUR   |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |   | MONTH DAY YEAR  |  | 3:30A M  |   |
| Marie A. Lang  |   | January 7, 1982   |  |  |   |
| 3. SEX   | 4. RACE   | 5. DATE OF BIRTH  | 6. AGE (IN YEARS LAST BIRTHDAY)                                  | IF UNDER 1 YEAR  |   |
| Female   | White   | MONTH DAY YEAR<br>April 8 1913  | 68   | IF UNDER 24 HRS  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |   |
| Maryland   |   | U.S.A.  |  | Baltimore City MD.   |   |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY   |
| Baltimore  | Maryland General Hospital   |   | Sales  |  | Dept. Store   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |   | 13b. INSIDE CITY LIMITS?  |  | 13c. STREET ADDRESS  |   |
| 13a. STATE   |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 1631 Sherwood Road   |   |
| Maryland   |   |   |  |  |   |
| 14. FATHER'S NAME  |   | 15. MOTHER'S MAIDEN NAME  |  |  |   |
| FIRST MIDDLE LAST<br>John Lang   |   | FIRST MIDDLE LAST<br>Magdalena Ruff   |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |   | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS  |   |
| No   |   | 216-05-5652   |  | Margaret Lang 1631 Sherwood Ave. Balto. Md.                                    |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial Infarction, Cardiac Standstill</u><br><u>4100</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Previous Myocardial Infarction</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Congestive Heart Failure, Pulmonary Edema</u> |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Eight Hours</u><br><u>Ten Days</u><br><u>Twelve Days</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).  |   |   |  |  |   |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?  |   |
|  |   |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |
| 22a. I certify that (this hospital) attended the deceased from <u>December 28</u> , 19 <u>81</u> , to <u>January 7</u> , 19 <u>82</u> , that <u>X</u> (we) last saw the deceased alive on <u>January 7</u> , 19 <u>82</u> , and that in <u>(X)</u> (our) opinion death occurred on the date and hour and from the causes stated above, <u>(X)</u> (we) (did) (did not) view the body after death.  |   | 22b. SIGNATURE<br><u>Harry Harris, M.D.</u><br>22b. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22c. DATE SIGNED<br>1/7/82   |   |
| 22b. SIGNATURE<br><u>Harry Harris, M.D.</u>  |   | 22b. ADDRESS<br>c/o Maryland General Hospital   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |   | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |   |
| Burial   |   | Jan. 11, 1982   |  | Loudon Park  |   |
| 24. FUNERAL DIRECTOR   |   | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR SIGNATURE   |   |
| NAME ADDRESS<br>Leonard J. Ruck, Inc. Baltimore, Md.   |   | JAN 8 1982  |  | <u>James S. Ruck</u>   |   |

1955



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 8 2 0 1 1 8 2<br>REG. NO.  |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  |   |  |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Annie MAARIE Langley</b>   |  |  |  | 2b. DATE OF DEATH MONTH DAY YEAR<br><b>1 / 6 / 82</b>  |  |   |  |
| 3 SEX<br><b>F</b>  |  | 4 RACE<br><b>B</b>   |  | 5 DATE OF BIRTH MONTH DAY YEAR<br><b>5 6 30</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS<br><b>51</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N. C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Sinai Hosp.</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><b>MD.</b>   |  |  |  | 13b. COUNTY<br><b>Balto</b>  |  | 13c. CITY OR TOWN<br><b>Balto</b>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Reartie</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Fessie</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>   |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>243 66 5519</b>   |  | 17. INFORMANT ADDRESS<br><b>Charles Langley 2911 Woodland Ave.</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Severe Mitral stenosis</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Rheumatic heart disease</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>30 min</b><br><b>Yrs</b><br><b>Yrs</b> |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>3940</b>   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION<br><b>NA</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>NA</b>  |  | 21c. HOW INJURY OCCURRED (GIVE NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, PARK, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/16</b> 19 <b>81</b> to <b>1/6</b> 19 <b>81</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated.  |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Stephenson</b>  |  | DEGREE<br><b>MD</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                 |  | 22c. DATE SIGNED<br><b>1/7/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>STEPHENSON</b>   |  |  |  | 22e. ADDRESS<br><b>5101 Lauier Ave., Balto., Md. 21215</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>1/9/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Church Cem.</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Mt. Olive</b>   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Wm. C. March E/H</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR SIGNATURE<br><b>JAN 7 1982</b> <b>James J. Smith</b>  |  |   |  |

1/18/82  
F  
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Baltimore C. 10  
M.C. 12A

Baltimore 21001 1000

Location - 1000

21001 1000

(Baltimore 21001)

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21001 1000

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1000

1/18/82 Church Comm. Mt. Olive  
M.C. 12A

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1 - FOR STATE REGISTRAR   |  |  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 8 2 0 1 1 8 3<br>REG. NO.   |  |  |  |
|---|--|--|--|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>MARY LARKINS   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>01-09-82   |  |  |  | 2b. HOUR<br>7:44 A.M.   |  |  |  |
| 3 SEX<br>FEMALE   |  | 4. RACE<br>BLACK   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11-13-1895  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>86 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  | IF UNDER 24 HRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTO. CITY MD.                                       |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>LUTHERAN HOSPITAL |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>DOMESTIC                 |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>FRT. FAMILY  |  |  |  |
| 13a. STATE<br>MARYLAND  |  |  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>BALTIMORE   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>BALTO. MD. 21216<br>2536 W. LAFAYETTE AVE.  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John W. Jones   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MARY WYATT   |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>216-18-3816  |  | 17. INFORMANT<br>CATONSVILLE ADDRESS MARYLAND 21228<br>Mr. William A. LARKINS 801 Bobby Road |  |   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CARCINOMA OF THE RECTUM<br>1541<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION<br>1-7-82  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>RECTAL BLEEDING 2nd CA. RECTUM  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)               |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| 22a. I certify that (if (this hospital) attended the deceased from 01-03-1982, to 01-09-1982, that (I) (we) lost saw the deceased alive on 01-09-1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br>Mehm Thau N. D.   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |  |  | 22c. DATE SIGNED<br>01-09-82  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MEHM T. THAU N   |  |  |  | 22e. ADDRESS<br>LUTHERAN HOSP. BALTO MD 21216   |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  |  |  | 23b. DATE<br>1-13-82  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>MT. AUBURN Cem.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE CITY, MD.                               |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>HERBERT E. NATTER   |  |  |  | ADDRESS<br>BALTIMORE<br>3035 W. NORTHMAN  |  | 25a. DATE REC'D. BY REGISTRAR<br>11 1982   |  | 25b. REGISTRAR'S SIGNATURE<br>James J. [Signature]  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 1 8 4

REG. NO.

|  |  |   |  |   |  |   |   |   |  |  |
|--|--|---|--|---|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Michael LaViola</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 28 82</b>                  |   |  | 2b. HOUR<br><b>8:40 AM</b>  |   |   |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>W</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 8 62</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b>  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Italy</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. City</b>                            |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Good Samaritan Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK OR SERVICE WORKING (IFE)<br><b>Ret. Stoker</b> |   | 12b. KIND OF BUSINESS OR<br><b>Balto. City</b>  |  |  |
| 13a. STATE<br><b>Md.</b>   |  |   | 13b. COUNTY  |   | 13c. CITY OR TOWN<br><b>Balto</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>5758 Cedonia Ave.</b>            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Dominic LaViola</b>   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Maria Chiccini</b>   |   |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  |   | 16b. SOCIAL SECURITY NO.<br><b>218-07-2812</b>                         |   | 17. INFORMANT<br>ADDRESS<br><b>Lena LaViola, 5758 Cedonia Ave.</b>   |   |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiovascular collapse</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Sepsis, Acute renal failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Sepsis &amp; Sepsis</b><br>0389       |  |   |  |   |  |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 0   |  |   |  |   |  |   |   |   |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>11 9 81</b>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br><b>8:40 AM 1/28/82</b>   |   |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>Balto. City</b>  |   |   |   |  |  |
| 22a. I certify that (this hospital) attended the deceased from <b>1/28/81</b> to <b>1/28/82</b> , that (I) (we) lost<br>saw the deceased alive on <b>1/28/81</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |   |   |  |  |
| 22b. SIGNATURE<br><b>Bhagpal</b>   |  |   |  |   | DEGREE <b>B. M. D.</b> MD H.O.<br>ATTENDING MEDICAL STAFF<br>PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |   |   | 22c. DATE SIGNED  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BEENA NAGPAL</b>   |  |   |  |   | 22e. ADDRESS   |   |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>2-1-82</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto., Md.</b>                                |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>LEONARD J. RUCK, INC.</b>   |  |   |  |   | ADDRESS<br><b>5305 HARFORD RD.</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 29 1982</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><i>Thomas J. [Signature]</i> |  |

1000

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 1 8 5

REG. NO.

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Anna M. LaVoie</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 17, 1982</b> |   |  | 2b. HOUR<br><b>11:00 AM</b>  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>July 8, 1931</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>50</b> YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD.</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore City</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>6116 Everall Ave.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>                                       |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Jerry C. Barile</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Katherine Lasseth</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  |  |  |
| 16b. SOCIAL SECURITY NO.<br><b>216-28-2911</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Andrew R. LaVoie, Jr. 6116 Everall Ave.</b>  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of the Pancreas</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last.       |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>16 months</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>77</b>  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>MAY 19</b> 19 <b>76</b> , to <b>JAN 17</b> 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>JAN. 7</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Walter R. Welzant</b> M.D.   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>JAN. 19, 1982</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Walter R. Welzant</b>   |  |   |  | 22e. ADDRESS<br><b>422-25 Medical Arts Building</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>Jan. 19, 1982</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley Mem.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Cockeysville Maryland</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J. Ruck, Inc. 5305 Harford Rd. Balt. Md.</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR BY REGISTRAR<br><b>JAN 20 1982</b>  |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified for an autopsy.



*[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]*

RECEIVED  
NOV 10 1950

CHICAGO  
VINTAGE  
LIBRARY

*[Faint handwritten text at the bottom left corner.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director and completely filled in by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filed within 72 hours after death. The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death. The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |   |  |   |  |
|--|--|--|--|---|--|---|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  |   | REG. NO. 8 2 0 1 1 8 6   |   |   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Thomas J. Lawler</b>   |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>January 28, 1982</b>                    |   |   | 2b. HOUR<br>M  |   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Sept. 24, 1906</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Penna.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                         |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Union Memorial Hospital</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired Repairman</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>C &amp; P Tele.</b>  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>   |  |  |  |   | 13b. COUNTY  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>                                 |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>William F. Lawler</b>  |  |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Rose B. Thomas</b>            |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>212-05-0523</b>   |  | 17. INFORMANT<br><b>Wife: Anna M. Lawler</b>  |  | ADDRESS<br><b>Balt., Md. 21206 4256 Sheldon Avenue</b>                                    |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>POSSIBLE MYOCARDIAL INFARCTION</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>(c) <b>A.S.C.W.D.</b>  |  |  |  |   |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |   |   |  |   |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>     |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  | 21e. PLACE OF INJURY (ATHLETIC FIELD, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION CITY OR TOWN COUNTY STATE  |   |   |  |   |  |
| 22a. I certify that (1) the hospital attended the deceased from _____, 19____, to _____, 19____, that (1) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) laid (and) saw the body after death.) |  |  |  |   |  |   |   |  |   |  |
| 22b. SIGNATURE<br><i>[Signature]</i>   |  |  |  |   | DEGREE   |   |   | 22c. DATE SIGNED<br><b>1/29/82</b>   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Luis E. Rivera M.D.</b>  |  |  |  |   | 22e. ADDRESS<br><b>5317 Belair Road Baltimore, Maryland</b>                    |   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Entombment</b>   |  |  | 23b. DATE<br><b>2/1/82</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens Of Faith</b>                  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b> |  |   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Leonard J. Ruck, Inc.</b>  |  |  |  |   | ADDRESS<br><b>Baltimore, Maryland</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 1 1982</b>                    |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |

January 25, 1961

Letter

1.

Thomas

78

Sept. 24, 1960

White

Black

Belmont City

U.S.A.

Black

Union Memorial Hospital

Belmont

Sept. 24, 1960

4830 Madison Avenue

X

Belmont

Black

Sept. 24, 1960

4830 Madison Avenue

NO

RECEIVED  
FBI - NEW YORK  
SEP 24 1960

A.2.W.D.



*[Handwritten signature]*

Belmont, N.Y.

NY 10017

Mr. J. Edgar Hoover

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 2 0 1 1 8 7   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>HATTIE LEBOWITZ</b>   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>JANUARY 27 1982</b>  |  | 2b. HOUR<br><b>4:20 PM</b>   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>CAUCASIAN</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>3 16 1886</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>95</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>RUSSIA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO CITY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO CITY</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSPITAL</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b>  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  | 13a. STREET ADDRESS<br><b>2500 W. BELVEDERE AVE. 21215</b>  |  |  |  |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>XXXXXXXX</b>  |  | 13c. CITY OR TOWN<br><b>BALTO</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>ABRAHAM BUCHMAN</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>FANNIE FURMAN</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>220-44-9788</b>  |  | 17. INFORMANT ADDRESS<br><b>MRS. FREDA GARELICK<br/>3505 WILD CHERRY RD. BALTO., MD 21207</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |   |  |   |  |  |  |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardio Pulmonary Arrest</b>  |  |   |  |   |  |  |  |
| 4292 } DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASCVD, congestive</b>  |  |   |  |   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) <b>Constriction of L3*</b>   |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION * <b>ANNE DIXON M.F. NOTIFIED BY DR. JASKULSKY (SINAI HOSP.) &amp; RELEASED</b> CITY OR TOWN COUNTY STATE                                     |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>JAN 16 19 82</b> , to <b>JAN 27 19 82</b> , that (I) (we) last saw the deceased alive on <b>JAN 27 19 82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Dr. R. Jaskulsky</b>   |  | DEGREE  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>1/27/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>S JASKULSKY MD</b>  |  | 22e. ADDRESS<br><b>SINAI Hosp of BALTO</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>JAN. 29, 1982</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>WORKMEN CIRCLE</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY<br><b>BALTIMORE</b> <b>North</b>   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b>  |  |   |  | 25a. DATE REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>FEB 2 1982</b>  |  |  |  |
| 6010 REISTERSTOWN RD. BALTO., MD 21215  |  |   |  |   |  |  |  |

BP

DHMM-16 20M  
(VRA 15, 4) 7/78



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 1 8 8

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MAUDE</b> FIRST <b>LEE</b> LAST   |  |   | 2a. DATE OF DEATH<br>MONTH <b>1</b> DAY <b>18</b> YEAR <b>82</b>                             |   | 2b. HOUR<br><b>M</b>   |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>Black</b>  | 5. DATE OF BIRTH<br>MONTH <b>2</b> DAY <b>28</b> YEAR <b>98</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>83</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>NC</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto. MD</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Duteland Nsg. Home</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Persake Nsg. Home</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>COOK</b>   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD</b>   |  | 13b. COUNTY<br><b>MD</b>  | 13c. CITY OR TOWN<br><b>Balto</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>201 N. Washington St.</b>  |
| 14. FATHER'S NAME<br>FIRST <b>Hayward</b> MIDDLE <b></b> LAST <b>Rogers</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Mary</b> MIDDLE <b></b> LAST <b>MARK</b>   |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>no</b>                   |  |
| 16b. SOCIAL SECURITY NO.<br><b>19-10-4152A</b>   |  | 17. INFORMANT<br><b>Novella Reaves</b>  |  | ADDRESS <b>201 N. Wash St</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4140 Cardio Respiratory Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Atherosclerotic Heart disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>S/P Pacemaker insertion</b>                             |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/14</b> 19 <b>81</b> , to <b>1/18</b> 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>1/2/82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |
| 22b. SIGNATURE<br><b>[Signature]</b>   |  | DEGREE  |  | 22c. DATE SIGNED<br><b>1/18/82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Rogers Gebremariam</b>   |  | 22e. ADDRESS  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>1/23/82</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Cemetery</b>                              |   | 23d. LOCATION<br>CITY OR TOWN <b>Baltimore</b> COUNTY <b></b> STATE <b>Md</b>  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>William C. March</b>  |  | ADDRESS<br><b>F/H 1101 E. North Ave</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 19 1982</b>   |  |
|  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 2 0 1 1 8 9   |  |  |  |
|---|--|---|--|---|--|--|--|
| FOR<br>STATE<br>REGISTRAR   |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>MARGARET V. LEESE</b>   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>1-29-82</b>  |  | 2b. HOUR<br><b>12:45</b> AM  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>June 15, 1896</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS<br><b>85</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. CITY</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNION MEMORIAL HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Weaver</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Cotton Mill</b>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                               |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Charles Shepherd</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Katie Shipley</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>213 05 0513</b>  |  | 17. INFORMANT ADDRESS<br><b>Earl L. Leese, 6 Begonia Court 21234</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASCVD</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>approx 1/2 hr</b> |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>COPD</b>  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1-27</b> 19 <b>82</b> to <b>1-28</b> 19 <b>82</b> that (I) (we) lost <del>now the deceased alive on</del> <b>1-28</b> 19 <b>82</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did/did not) view the body after death.   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Patricia Walsh</b> M.D.  |  |   |  | 22c. DATE SIGNED<br><b>1-29-82</b>  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>PATRICIA WALSH</b>   |  |
| 22e. ADDRESS<br><b>202 E UNW Pkwy BALTO MD</b>  |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>Feb 1, 1982</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Park</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Woodlawn, Balto Co., Maryland</b>  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Burgee Funeral Home, Baltimore, Md.</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 1 1982</b>  |  |  |  |
|   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles J. ...</b>   |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must stay retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO. 8201190   |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) BESSIE C LEGUS   |  |   |  | JANUARY 11, 1982 0655 AM   |  |  |  |
| 2. SEX FEMALE   |  | 4. RACE CAUCASIAN   |  | 5. DATE OF BIRTH MONTH DAY YEAR MAY 7, 1918  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.  |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.  |  |
| 10. CITY OR TOWN OF DEATH BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY OF MARYLAND |  | 12a. USUAL OCCUPATION (TYPE WORK FOR MOST OF WORKING LIFE) RETIRED   |  | 12b. KIND OF BUSINESS OR INDUSTRY DUPONT IND.  |  |
| 13a. STATE VIRGINIA 13b. COUNTY HENRY 13c. CITY OR TOWN COLLINSVILLE  |  |   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS 213 ELIZA REAMEY AVE.  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST ROBERT NMN COLE   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARTHA STIERS   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE NO UNKNOWN) UNK   |  | 16b. SOCIAL SECURITY NO. 240-18-1643  |  | 17. INFORMANT ADDRESS (SAME ADDRESS) WILLIAM S. LEGUS, HUSBAND   |  |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CARDIAC DYSRHYTHMIA<br>1990<br>DUE TO, OR AS A CONSEQUENCE OF (b) PULMONARY FAILURE<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>DUE TO, OR AS A CONSEQUENCE OF (c) ABENOCARCINOMA, DISSEMINATED<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>15 MINUTES<br>3 WEEKS<br>5 MONTHS |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a) RENAL FAILURE   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION 12/10/81   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED PERICARDIAL TAMPONADE  |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from NOV. 30, 19 81, to JAN 11, 19 82, that (we) last saw the deceased alive on JAN 11, 19 82, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (did) (didn't) view the body after death.   |  |   |  |  |  |  |  |
| 22b. SIGNATURE OF PHYSICIAN   |  |   |  | DEGREE   |  | 22c. DATE SIGNED 1/11/82   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL B. STEWART, M.D.  |  |   |  | 22e. ADDRESS BALTIMORE CANCER RESEARCH CTR.  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL  |  | 23b. DATE 1-14-82   |  | 23c. NAME OF CEMETERY OR CREMATORY ROSELAWN BURIAL PK  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE MARTINSVILLE HENRY VA.   |  |
| 24. FUNERAL DIRECTOR NAME E BARNES ADDRESS REMIAS FUNERAL SERVICE BENSON MD   |  |   |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JAN 26 1982 James J. [Signature]  |  |  |  |

MEDICAL CERTIFICATION

THURSDAY 11 JULY 1962

1. 10.00 AM - 11.00 AM

2. 11.00 AM - 12.00 PM

3. 12.00 PM - 1.00 PM

4. 1.00 PM - 2.00 PM

5. 2.00 PM - 3.00 PM

6. 3.00 PM - 4.00 PM

7. 4.00 PM - 5.00 PM

8. 5.00 PM - 6.00 PM

9. 6.00 PM - 7.00 PM

10. 7.00 PM - 8.00 PM

11. 8.00 PM - 9.00 PM

12. 9.00 PM - 10.00 PM

13. 10.00 PM - 11.00 PM

14. 11.00 PM - 12.00 AM

15. 12.00 AM - 1.00 AM

16. 1.00 AM - 2.00 AM

17. 2.00 AM - 3.00 AM

BP  
DHMH-16 50AM 1/81  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO.   |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>LESTER F. LEONARD</b>  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>1/24/82</b> 2b. HOUR<br><b>4:30 AM</b>  |  |   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>11 10 03</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Agnes Hospital</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Bartender</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Bar</b>   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b> 13b. COUNTY<br><b>Baltimore</b> 13c. CITY OR TOWN<br><b>Baltimore</b> 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |  | 13e. STREET ADDRESS<br><b>2427 Ashton Street 21223</b>   |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>George Leonard</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Grace Leonard</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>215-07-1825</b>  |  | 17. INFORMANT ADDRESS<br><b>Charles L. DiGrestine 3045 Hickory Mede Dr. 21043</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4960 Congestive Heart Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Myocardial Ischemia</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>COPD</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Rectal Carcinoma with metastasis to Urinary system</b>   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1-16</b> , 19 <b>82</b> , to <b>1-24</b> , 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>1-24</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.                           |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Lawrence Zeidman</b> DEGREE <b>MD</b>   |  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |  | 22c. DATE SIGNED<br><b>1-24-82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Lawrence Zeidman</b>   |  |   |  | 22e. ADDRESS<br><b>St. Agnes Hospital</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>1/27/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Hubbard Funeral Home, Inc.</b>   |  |   |  | 24b. ADDRESS<br><b>4107 Wilkens Ave.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 27 1982</b>   |  |
|  |  |   |  | 25b. REGISTRAR<br><b>James J. [Signature]</b>  |  |   |  |



*[Faint, mostly illegible text at the top of the page, possibly a header or introductory paragraph.]*

*[Large block of faint, mostly illegible text in the middle of the page, appearing to be the main body of a letter or report.]*

*[Faint text at the bottom of the page, possibly a signature, date, or footer.]*

*[Vertical text on the right margin, possibly a date or reference number, written from bottom to top.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1, and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 1 9 2

REG. NO.

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>William A. Leonard  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>January 30, 1982                     |  | 2b. HOUR<br>9:30A M  |
| 3. SEX<br>M  | 4. RACE<br>WHITE   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 17 1902  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>79 YRS.                                  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD.   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Maryland General Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>RETIRED | 12b. KIND OF BUSINESS OR INDUSTRY<br>SELF  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD.  |  |   | 13b. COUNTY   | 13c. CITY OR TOWN<br>BALTO.  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>GEORGE W. LEONARD  |  |   | 15. MOTHER'S MAIDEN NAME<br>MIDDLE LAST<br>MAGGIE RIDER                     |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>26-01-3916   | 17. INFORMANT ADDRESS<br>ANNA LEONARD SAME 21224                            |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Multiple System Organ Failure<br>0389<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>DO TO, OR AS A CONSEQUENCE OF Generalized Sepsis<br>(b)<br>DO TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (X) (this hospital) attended the deceased from January 18, 1982, to January 30, 1982, that (X) (we) lost saw the deceased alive on January 30, 1982, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.  |  |   |   |  |  |
| 22b. SIGNATURE<br>Ahmad Akar, M.D.   |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED<br>1/30/82  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Ahmad Akar, M.D.  |  | 22e. ADDRESS<br>c/o Maryland General Hospital   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(REVIEW)<br>BURIAL  | 23b. DATE<br>2-3-81  | 23c. NAME OF CEMETERY OR CREMATORY<br>OAKLAWN CEM.  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY<br>BALTO. MD  |  |
| 24. FUNERAL DIRECTOR<br>Hoffman-Skarda   |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 1 1982   |   | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |

MEDICAL CERTIFICATION



105-10

January 10, 1962

San Francisco

105-10

San Francisco

Internal Security - Communist

San Francisco

Subject of 105-10, San Francisco

Confidential Source

January 10, 1962

San Francisco

January 10, 1962

Internal Security - Communist

San Francisco

105-10



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DHMH - 16 50M 1/B1  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

82 01193

REG. NO.

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 2a. DATE OF DEATH  |  | 2b. HOUR   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | 3. SEX   |  | 4. RACE  |  |
| ELMER A. LESLIE  |  | MALE   |  | White  |  |
| 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                       |  |
| DEC 14 1895  |  | 86 YRS.  |  | MARYLAND   |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  | 10. CITY OR TOWN OF DEATH  |  |
| BALTIMORE  |  | BALTIMORE CITY MD.   |  | BALTIMORE  |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| UNIV. OF MARYLAND Hosp.  |  | unemployed   |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  |
| Maryland   |  | BALTIMORE  |  | BALTIMORE  |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)            |  |
| Charles  |  | Annie  |  | yes  |  |
| 17. INFORMANT  |  | 18. SOCIAL SECURITY NO.  |  | 19. ADDRESS  |  |
| ER Computer Hx.  |  | 217-10-0680  |  | ER Computer Hx.  |  |
| 20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |  | 21. IMMEDIATE CAUSE (a)  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                   |  |
| 4280   |  | CARDIAC ARREST   |  | immediate  |  |
| 22. DUE TO, OR AS A CONSEQUENCE OF   |  | 23. DUE TO, OR AS A CONSEQUENCE OF   |  | 24. DUE TO, OR AS A CONSEQUENCE OF   |  |
| End Stage Congestive Heart Failure.  |  |  |  | 3 years.   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a  |  |  |  |  |  |
| Atrial Fibrillation, Renal Failure   |  |  |  |  |  |
| 25a. DATE OF OPERATION   |  | 25b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 26a. AUTOPSY?  |  |
|  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |
| 27a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 27b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR  |  | 27c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
|  |  | P.M. 19  |  |  |  |
| 28a. INJURY OCCURRED   |  | 28b. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 28c. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  |  |  |  |
| 29. I certify that (I) (this hospital) attended the deceased from DEC 24 19 81, to JAN 11 19 82, that (II) I saw the deceased alive on JAN 11 19 82, and that in (my) opinion death occurred on the date and hour and from the causes stated above, and (did) did not view the body after death. |  |  |  |  |  |
| 30. SIGNATURE  |  | 31. DEGREE   |  | 32. DATE SIGNED  |  |
| Stephen M. Puentes, M.D.   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | JAN 11/1982  |  |
| 33. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 34. ADDRESS  |  |  |  |
| Stephen M. Puentes, M.D.   |  | UNIV. OF MARYLAND Hosp.  |  |  |  |
| 35. BURIAL, CREMATION, REMOVAL   |  | 36. DATE   |  | 37. NAME OF CEMETERY OR CREMATORY  |  |
| Burial   |  | Jan 14, 1982   |  | Mt. Olivet Cemetery  |  |
| 38. FUNERAL DIRECTOR   |  | 39. DATE REC'D. BY REGISTRAR   |  | 40. REGISTRAR'S SIGNATURE  |  |
| Smith, Keeney, Basford Funeral Home  |  | JAN 18 1982  |  |  |  |
| 106 East Church St., Frederick, Md. 21701  |  |  |  |  |  |

BP

JAN 18 1982

100 West 12th Street, New York, N.Y. 10011

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Items 21a.-21f. &amp; 22.

FOR  
STATE  
REGISTRAR  
AL

Film# G568 6-29-82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 1 9 4

REG. NO.

|   |  |   |   |   |   |  |   |  |   |  |
|---|--|---|---|---|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>KUZMA Lesniak</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 16 82</b>                                 |   |   | 2b. HOUR<br><b>2:05 PM</b>   |   |  |   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov 14, 1896</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS.<br><b>85</b>   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Russia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. City</b>                                       |   |  | MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Union Memorial Hospital</b> |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Labor</b>                 |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Sugar Refine.</b>  |   |  |
| 13a. STATE<br><b>Maryland</b>   |  |   | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>3744 Ellerslie Avenue</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>(un known)</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>(unknown)</b>                     |   |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>212 09 5992</b>         |   | 17. INFORMANT<br>ADDRESS<br><b>Sonia Lesniak 3744 Ellerslie Ave Baltimore</b> |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4310</b> IMMEDIATE CAUSE (a) <b>Intracerebral bleed</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Fall</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |  |   |   |   |   |  |   |  |   |  |
| 19a. DATE OF OPERATION<br><b>12/82, 1/6/82</b>  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Intracerebral bleed</b>        |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. Unknown 19</b>             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>unknown</b> |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>home</b> |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>Patients home address</b>                |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>JAN 12, 19 81</b> , to <b>JAN 16, 19 81</b> , that (I) (we) lost<br>saw the deceased alive on <b>JAN 16, 19 81</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. <b>Natural</b>             |  |   |   |   |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>G. Patsy Riley</b>   |  |   |   |   |   | DEGREE<br><b>MD</b>  |   | 22c. DATE SIGNED<br><b>1-16-82</b>   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>G. Patsy Riley</b>  |  |   |   |   |   | 22e. ADDRESS<br><b>201 E. University Pkwy</b>  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |   | 23b. DATE<br><b>Jan 20, 82</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Memorial</b>                |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Dipol Funeral Homes, Inc.</b>  |  |   |   |   |   | ADDRESS<br><b>7110 Belair Road</b>   |   | 25a. DATE REC'D BY REGISTRAR<br><b>JAN 18 1982</b>   |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 8 2 0 1 1 9 5  |  |   |  |
|--|--|--|--|--|--|---|--|
| 1- FOR STATE REGISTRAR   |  |  |  | REG. NO.   |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <u>Arthur L. Lewis</u>   |  |  |  | 2a. DATE OF DEATH MONTH <u>1</u> DAY <u>14</u> YEAR <u>82</u> 10:28 AM   |  |   |  |
| 3. SEX <u>Male</u>   |  | 4. RACE <u>Black</u>   |  | 5. DATE OF BIRTH MONTH <u>6</u> DAY <u>13</u> YEAR <u>1895</u>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <u>86</u> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Virginia</u>  |  | 7b. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City, Maryland MD.</u>  |  |
| 10. CITY OR TOWN OF DEATH <u>Baltimore</u>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>North Charles General Hospital</u> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Foreman</u>   |  | 12b. KIND OF BUSINESS OR INDUSTRY <u>American Ave</u>   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  | 13a. STREET ADDRESS <u>3300 Liberty Hghts. Ave</u>   |  |   |  |
| 13a. STATE <u>Maryland</u>   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN <u>Baltimore</u>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST <u>Lazarus</u> MIDDLE LAST <u>Lewis</u>  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST <u>Sarah</u> MIDDLE LAST <u>Fitzgerald</u>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>  |  | 16b. SOCIAL SECURITY NO. <u>212-01-7885</u>  |  | 17. INFORMANT <u>Balto., Md.</u> ADDRESS <u>21215 Hghts. Ave</u>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Hemoptysis, Massive</u>   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>LUNG CARCINOMA</u>   |  |  |  |  |  |   |  |
| (c) <u>SALMONELLA sepsis</u>   |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/14/82</u> to <u>1/14/82</u> that (I) (we) last saw the deceased alive on <u>1/14/82</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE <u>Marcos B. Galicia Jr.</u> DEGREE <u>MD</u>   |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 22c. DATE SIGNED <u>1/14/82</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>MARCOS B. GALICIA Jr. MD</u>  |  |  |  | 22e. ADDRESS <u>North Charles GEN. Hosp.</u>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>  |  | 23b. DATE <u>1/19/82</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Arbutus Mem. Park</u>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Baltimore County Maryland</u>  |  |
| 24. FUNERAL DIRECTOR NAME <u>BALTIMORE</u> ADDRESS <u>MARYLAND 21216</u>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR <u>JAN 18 1982</u> REGISTRAR SIGNATURE <u>Francis J. [Signature]</u>   |  |   |  |
| HERBERT E. NUTTAL FUNERAL HOME 3035 W. NORTH AVE   |  |  |  |  |  |   |  |

CONFIDENTIAL  
JAN 19 1960



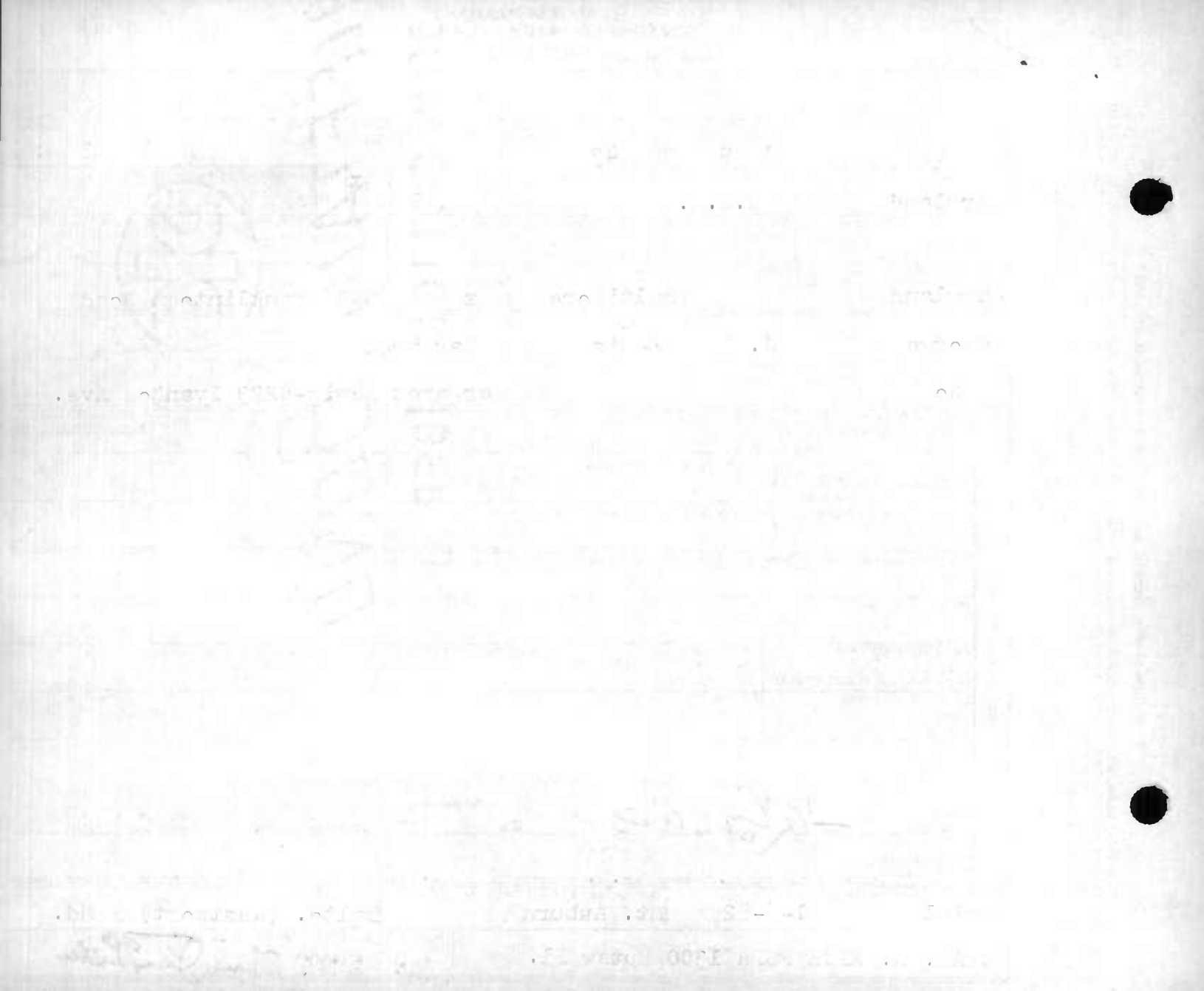
CONFIDENTIAL



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| FOR<br>1- STATE<br>REGISTRAR   |  |         |  |                                    |  |                                    |  |                |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                                |  |            |   |          |  |              |  | REG. NO.  |  |                |  |            |  |          |  |              |  |               |  |
|--|--|---------|--|------------------------------------|--|------------------------------------|--|----------------|--|---|--|--------------------------------|--|------------|---|----------|--|--------------|--|---|--|----------------|--|------------|--|----------|--|--------------|--|---------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |         |  |                                    | FIRST<br>Harold  |                                    |  |                |  | MIDDLE<br>Lewis   |  |                                |  |            | LAST  |          |  |              |  | 2b. DATE KNOWN<br>OF DEATH                      |  | ESTI-<br>MATED |  | MONTH<br>1 |  | DAY<br>1 |  | YEAR<br>1982 |  | 2d. HOUR<br>M |  |
| 3. SEX   |  | 4. RACE |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR |  | 6. AGE (IN YEARS<br>LAST BIRTHDAY) |  | IF UNDER 1 YR. |  | IF UNDER 24 HRS.  |  | 7c. DATE<br>PRONOUNCED<br>DEAD |  | MONTH<br>1 |   | DAY<br>1 |  | YEAR<br>1982 |  | 2d. HOUR<br>M                                   |  |                |  |            |  |          |  |              |  |               |  |
| male   |  | black   |  | 1 9 38                             |  | 43 YRS.                            |  |                |  |   |  |                                |  |            |   |          |  |              |  | 6:51  |  |                |  |            |  |          |  |              |  |               |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)   |  |         |  |                                    | 7b. CITIZEN OF WHAT COUNTRY?   |                                    |  |                |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                                |  |            | 9. BALTIMORE CITY OR COUNTY OF DEATH  |          |  |              |  | AM  |  |                |  |            |  |          |  |              |  |               |  |
| Maryland   |  |         |  |                                    | U.S.A.   |                                    |  |                |  |   |  |                                |  |            | Baltimore City  |          |  |              |  | MD.   |  |                |  |            |  |          |  |              |  |               |  |
| 10. CITY OR TOWN OF DEATH  |  |         |  |                                    | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                    |  |                |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)  |  |                                |  |            | 12b. KIND OF BUSINESS<br>OR INDUSTRY  |          |  |              |  |   |  |                |  |            |  |          |  |              |  |               |  |
| Baltimore  |  |         |  |                                    | 2900 blk Borgers Lane  |                                    |  |                |  |   |  |                                |  |            |   |          |  |              |  |   |  |                |  |            |  |          |  |              |  |               |  |
| 13a. STATE   |  |         |  |                                    | 13b. COUNTY  |                                    |  |                |  | 13c. CITY OR TOWN   |  |                                |  |            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |          |  |              |  | 13e. STREET ADDRESS                             |  |                |  |            |  |          |  |              |  |               |  |
| Maryland   |  |         |  |                                    |  |                                    |  |                |  | Baltimore   |  |                                |  |            |   |          |  |              |  | 902 Franklintown Road                           |  |                |  |            |  |          |  |              |  |               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |  |         |  |                                    | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST  |                                    |  |                |  |   |  |                                |  |            |   |          |  |              |  |   |  |                |  |            |  |          |  |              |  |               |  |
| George J. Lewis  |  |         |  |                                    | Margaret Lewis   |                                    |  |                |  |   |  |                                |  |            |   |          |  |              |  |   |  |                |  |            |  |          |  |              |  |               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |  |         |  |                                    | 16b. SOCIAL SECURITY NO.   |                                    |  |                |  | 17. INFORMANT   |  |                                |  |            | ADDRESS   |          |  |              |  |   |  |                |  |            |  |          |  |              |  |               |  |
| No   |  |         |  |                                    |  |                                    |  |                |  | Margaret Lewis-4223 Ivanhoe Ave.  |  |                                |  |            |   |          |  |              |  |   |  |                |  |            |  |          |  |              |  |               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |         |  |                                    |  |                                    |  |                |  |   |  |                                |  |            |   |          |  |              |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |                |  |            |  |          |  |              |  |               |  |
| PART 1 DEATH WAS CAUSED BY:  |  |         |  |                                    |  |                                    |  |                |  |   |  |                                |  |            |   |          |  |              |  |   |  |                |  |            |  |          |  |              |  |               |  |
| IMMEDIATE CAUSE (a) Acute ethanol intoxication   |  |         |  |                                    |  |                                    |  |                |  |   |  |                                |  |            |   |          |  |              |  |   |  |                |  |            |  |          |  |              |  |               |  |
| 3030   |  |         |  |                                    |  |                                    |  |                |  |   |  |                                |  |            |   |          |  |              |  |   |  |                |  |            |  |          |  |              |  |               |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |         |  |                                    |  |                                    |  |                |  |   |  |                                |  |            |   |          |  |              |  |   |  |                |  |            |  |          |  |              |  |               |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |  |         |  |                                    |  |                                    |  |                |  |   |  |                                |  |            |   |          |  |              |  |   |  |                |  |            |  |          |  |              |  |               |  |
| (b)  |  |         |  |                                    |  |                                    |  |                |  |   |  |                                |  |            |   |          |  |              |  |   |  |                |  |            |  |          |  |              |  |               |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |         |  |                                    |  |                                    |  |                |  |   |  |                                |  |            |   |          |  |              |  |   |  |                |  |            |  |          |  |              |  |               |  |
| (c)  |  |         |  |                                    |  |                                    |  |                |  |   |  |                                |  |            |   |          |  |              |  |   |  |                |  |            |  |          |  |              |  |               |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |         |  |                                    |  |                                    |  |                |  |   |  |                                |  |            |   |          |  |              |  |   |  |                |  |            |  |          |  |              |  |               |  |
| arteriosclerotic cardiovascular disease  |  |         |  |                                    |  |                                    |  |                |  |   |  |                                |  |            |   |          |  |              |  |   |  |                |  |            |  |          |  |              |  |               |  |
| 19a. DATE OF OPERATION   |  |         |  |                                    | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |                                    |  |                |  |   |  |                                |  |            | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |          |  |              |  |   |  |                |  |            |  |          |  |              |  |               |  |
|  |  |         |  |                                    |  |                                    |  |                |  |   |  |                                |  |            |   |          |  |              |  |   |  |                |  |            |  |          |  |              |  |               |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |         |  |                                    | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR  |                                    |  |                |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |                                |  |            |   |          |  |              |  |   |  |                |  |            |  |          |  |              |  |               |  |
|  |  |         |  |                                    | P.M. 19  |                                    |  |                |  |   |  |                                |  |            |   |          |  |              |  |   |  |                |  |            |  |          |  |              |  |               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |         |  |                                    | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)   |                                    |  |                |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |                                |  |            |   |          |  |              |  |   |  |                |  |            |  |          |  |              |  |               |  |
|  |  |         |  |                                    |  |                                    |  |                |  |   |  |                                |  |            |   |          |  |              |  |   |  |                |  |            |  |          |  |              |  |               |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |         |  |                                    |  |                                    |  |                |  |   |  |                                |  |            |   |          |  |              |  |   |  |                |  |            |  |          |  |              |  |               |  |
| ACTUAL SIGNATURE <i>J.R. Guard</i>   |  |         |  |                                    |  |                                    |  |                |  | TITLE (SPECIFY)<br>Assistant MEDICAL EXAMINER   |  |                                |  |            |   |          |  |              |  | DATE SIGNED 1/1/82                              |  |                |  |            |  |          |  |              |  |               |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |  |         |  |                                    |  |                                    |  |                |  | ADDRESS   |  |                                |  |            |   |          |  |              |  |   |  |                |  |            |  |          |  |              |  |               |  |
| Hormez R. Guard, M.D.  |  |         |  |                                    |  |                                    |  |                |  | 111 Penn Street, Balto., MD 21201   |  |                                |  |            |   |          |  |              |  |   |  |                |  |            |  |          |  |              |  |               |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  |         |  |                                    | 23b. DATE  |                                    |  |                |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |                                |  |            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |          |  |              |  |   |  |                |  |            |  |          |  |              |  |               |  |
| Burial   |  |         |  |                                    | 1-6-82   |                                    |  |                |  | Mt. Auburn  |  |                                |  |            | Balto. (Westport) Md.   |          |  |              |  |   |  |                |  |            |  |          |  |              |  |               |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS   |  |         |  |                                    |  |                                    |  |                |  | 25a. DATE REC'D. BY REGISTRAR   |  |                                |  |            |   |          |  |              |  | 25b. REGISTRAR'S SIGNATURE                      |  |                |  |            |  |          |  |              |  |               |  |
| CHAS. A. RICE FSPA 1300 Eutaw Pl.  |  |         |  |                                    |  |                                    |  |                |  | JAN 5 1982  |  |                                |  |            |   |          |  |              |  | <i>James J. Nathan</i>                          |  |                |  |            |  |          |  |              |  |               |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the physician, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |   |  |   |  |
|--|--|---|--|---|--|---|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  |   |  |   | REG. NO.   |   |   |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   |  |   | 2a. DATE OF DEATH  |   |   | 2b. HOUR   |   |  |
| John P. Lezon  |  |   |  |   | January 21, 1982   |   |   | 6:58PM   |   |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |   | IF UNDER 1 YEAR  |   |  |
| MALE   |  | WHITE   |  | AUG. 31, 1916   |  | 65 YRS.   |   | MONTHS DAYS HOURS MIN.   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |   |  |   |  |
| VIRGINIA   |  | USA   |  |   |  | Baltimore City MD.  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)    |   | 12b. KIND OF BUSINESS OR INDUSTRY                              |   |  |
| Baltimore  |  | Maryland General Hospital   |  |   |  | SUPERVISOR  |   | WAREHOUSE  |   |  |
| 13a. STATE   |  |   |  |   | 13b. COUNTY  |   | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?                        |  |
| MD.  |  |   |  |   | BALTIMORE  |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS                             |  |
|  |  |   |  |   |  |   | 1602 PARK AVE.  |  |   |  |
| 14. FATHER'S NAME  |  |   |  |   | 15. MOTHER'S MAIDEN NAME   |   |   |  |   |  |
| JOSEPH LEZON   |  |   |  |   | CATHERINE  |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |   |  |   | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT ADDRESS   |  |   |  |
| YES  |  |   |  |   | WW2  |   | 215-09-5240   |  |   |  |
|  |  |   |  |   | STANLEY J. LEZON   |   |   | 808 DARTMOUTH RD.  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:   |  |   |  |   |  |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| IMMEDIATE CAUSE (a) <u>Respiratory Failure</u>   |  |   |  |   |  |   |   |  | 2:30-6:58PM                                     |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |   |  |   |  |   |   |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |  |   |  |   |  |   |   |  |   |  |
| b) <u>Congestive Heart Failure; Not Compensated</u>  |  |   |  |   |  |   |   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |   |  |   |  |   |   |  |   |  |
| c) <u>Severe Triple Vessel Disease</u>   |  |   |  |   |  |   |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |   |   |  |   |  |
| <u>Probable Supraventricular Tachycardia</u>   |  |   |  |   |  |   |   |  |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |   |  |
|  |  |   |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |   |  |   |  |
|  |  |   |  |   |  |   |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |  |   |  |
|  |  |   |  |   |  |   |   |  |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>January 21, 1982</u> , to <u>January 21, 1982</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>January 21, 1982</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did not view the body after death. |  |   |  |   |  |   |   |  |   |  |
| 22b. SIGNATURE   |  |   |  |   | DEGREE   |   |   | 22c. DATE SIGNED   |   |  |
| John Vitarello Jr. M.D.  |  |   |  |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |   | 1/21/82  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   |  |   | 22e. ADDRESS   |   |   |  |   |  |
| John Vitarello, M. D.  |  |   |  |   | c/o Maryland General Hospital  |   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |   | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |  |   |  |
| BURIAL   |  |   | JAN. 25, 1982  |   | NEW CATHEDRAL CEM.   |   | BALTIMORE MD.   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS   |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE  |  |   |  |
| MITCHELL-WIEDEFELD HOME 6500 YORK RD. 21212  |  |   |  |   | JAN 27 1982  |   | James J. Nathan   |  |   |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 1 9 8

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |  |  |  |  |  |   |  |   |  |  |  |
|---|--|--|--|--|--|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Joseph</b>  |  |  | MIDDLE<br><b>Liberto</b>   |  |  | LAST<br><b>Liberto</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 / 11 / 82</b>                                       |  |   | 2b. HOUR<br><b>11 00 P.M.</b>  |  |  |
| 3. SEX<br><b>Male</b>   |  |  | 4. RACE<br><b>White</b>  |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 18 96</b>   |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>85</b> YRS.   |  |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>4604 Colherne Road</b> |  |  |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Deputy Sheriff</b>       |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Retired Belt.</b>  |  |  |
| 13a. STATE<br><b>Maryland</b>   |  |  | 13b. COUNTY  |  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   | 13e. STREET ADDRESS<br><b>4604 Colherne Road 21229</b>   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joseph</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Rose D'anna</b>  |  |  |  |  |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WWI</b>  |  |  | 17. INFORMANT<br><b>Mrs. Sarah Liberto</b>   |  |  | ADDRESS<br><b>Same as # 13</b>  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arterio-sclerotic Cardio-vascular disease.</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |  |  |  |  |  |  |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |  |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>January</b> , 19 <b>75</b> , to <b>1/11</b> , 19 <b>82</b> , that (I) (we) lost<br>saw the deceased alive on <b>1/11</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Joseph R. Liberto</b>  |  |  | DEGREE<br><b>M.D.</b>  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>       |  |  | 22c. DATE SIGNED<br><b>1/12/82</b>  |  |   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JOSEPH R. LIBERTO, M.D.</b>   |  |  | 22e. ADDRESS<br><b>3508 Bunk St. Baltimore, Md. 21224</b>  |  |  |  |  |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>1/15/82</b>  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral Cemetery</b>  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>                              |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Witzke P.A.</b>  |  |  |  |  |  | ADDRESS<br><b>1630 Edmondson Avenue, Catonsville, Maryland</b>   |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 14 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>James J. K... ..</b> |  |  |  |

UNITED STATES DEPARTMENT OF JUSTICE

WASHINGTON, D. C. 20535  
JULY 10, 1964  
MEMORANDUM FOR THE ATTORNEY GENERAL  
SUBJECT: [Illegible]

[Extremely faint and mostly illegible body text, appearing to be a memorandum or report.]

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 1 9 9

1- FOR  
STATE  
REGISTRAR

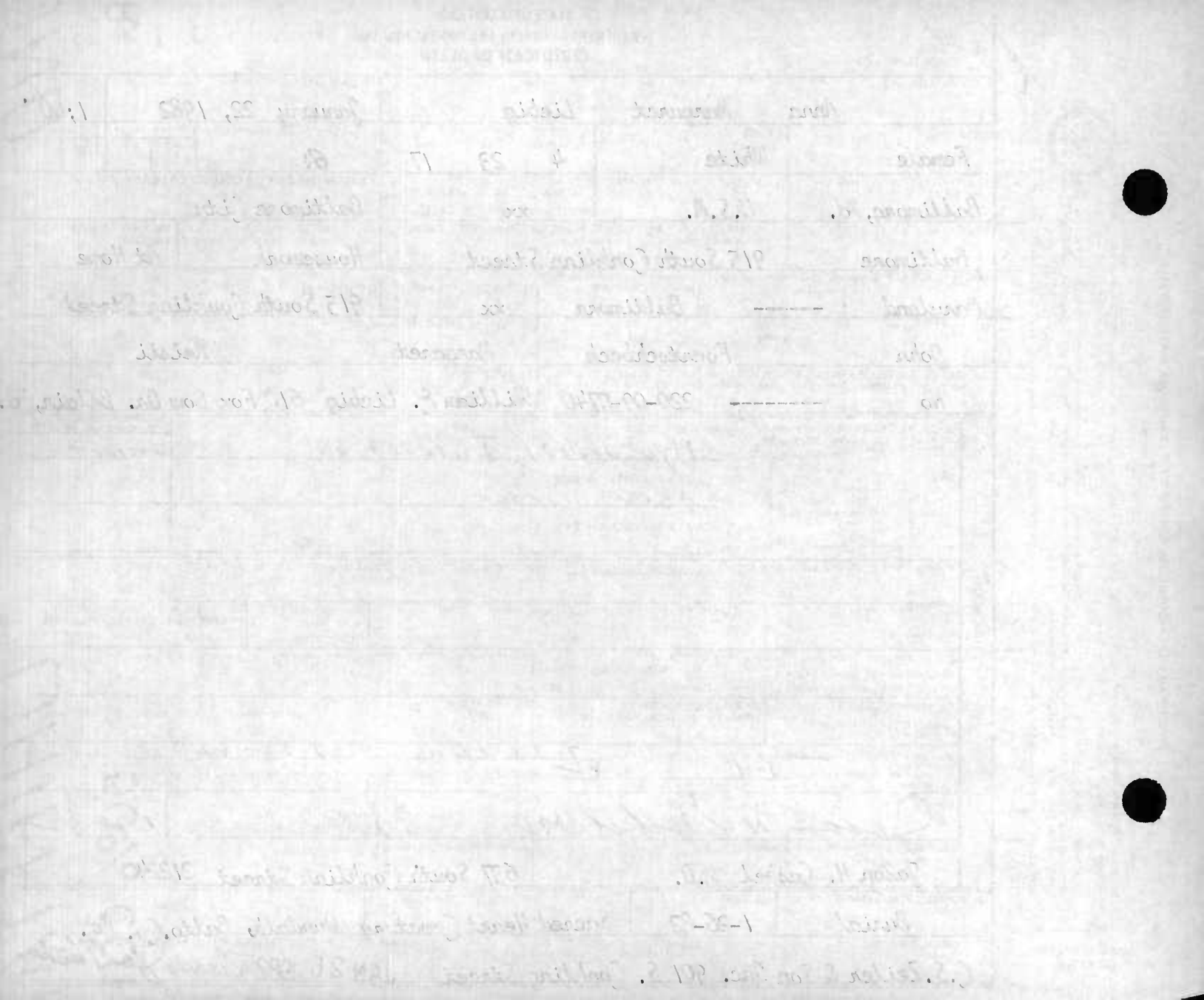
REG. NO.

|  |  |  |   |   |   |   |  |  |
|--|--|--|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Anna Margaret Liebig  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>January 22, 1982 |   |   | 2b. HOUR<br>A. M.<br>1:00   |  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4 23 17   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>64 YRS.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Baltimore, Md.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>915 South Conkling Street |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housework |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>At Home   |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>-----   |   | 13c. CITY OR TOWN<br>Baltimore  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Foertschbeck  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Margaret Reisii  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>-----<br>220-09-9740  |   | 17. INFORMANT<br>ADDRESS<br>William E. Liebig 610 Fox Bow Dr. Belair, Md.   |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Myocardial Infarction<br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) ASCV Disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) -----<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>Instant. |  |  |   |   |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |   |   |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>     |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from 7-24-82, 1982, to 7-22-82, 1982, that (I) (we) last saw the deceased alive on 7-4-82, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |  |   |   |   |   |  |  |
| 22b. SIGNATURE<br>Jason H. Gaskel M.D.   |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |   | 22c. DATE SIGNED<br>1-25-82   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Jason H. Gaskel M.D.  |  |  |   | 22e. ADDRESS<br>637 South Conkling Street 21224   |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>1-26-82   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Sacred Heart Cemetery   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Dundalk, Balto Co, Md.                            |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>C.S. Zeiler & Son Inc. 901 S. Conkling Street  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>JAN 26 1982  |   |   |  |  |
|  |  |  |   | 25b. REGISTRAR'S SIGNATURE<br>Francis J. Nathan   |   |   |  |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 8 2 0 1 2 0 0   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><i>Chun Kyung Lim</i>   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>January 25, 1982</i>  |  | 2b. HOUR<br><i>10:54 AM</i>  |  |
| 3 SEX<br><i>Male</i>   |  | 4 RACE<br><i>Korean</i>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>Dec. 2, 1900</i>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>81</i> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Korea</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>Korea</i>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD   |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore City</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Sinai Hospital</i> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Retired</i>  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><i>Maryland</i>  |  |  |  | 13b. COUNTY<br><i>Baltimore</i>   |  | 13c. CITY OR TOWN<br><i>Catonsville</i>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Chul Soo Lim</i>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Yung Ja Lim</i>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><i>215-82-0631</i>  |  | 17. INFORMANT <i>Mr. Kong Jik Lim</i><br><i>2nd Union Hall Ct. Catonsville, MD. 21228</i>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>4149 Congestive heart failure</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>C.A.D. ASCVD + Ischemia</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Dec 29, 1981</i> to <i>Jan 25, 1982</i> , that (I) (we) lost<br>saw the deceased alive on <i>Jan 25, 1982</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><i>M. N. Chung</i>   |  |  |  | DEGREE<br><i>MD</i>   |  | 22c. DATE SIGNED<br><i>1/26/82</i>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Dr. Myung Chung M.D.</i>   |  |  |  | 22e. ADDRESS<br><i>5670 The Alameda Balto.</i>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>  |  | 23b. DATE<br><i>1-27-82</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Meadowridge Cemetery</i>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Elkridge, Howard Prince Georges</i>                                       |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>Loring Byers Funeral Directors, Inc.<br/>8728 Liberty Road Randallstown, Maryland 21133</i>   |  |  |  | 25. DATE REC'D. BY REGISTRAR<br><i>JAN 26 1982</i>  |  |  |  |

1711 So. 6th St. S. 1711

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 15 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 2 0 1

REG. NO.

|   |  |  |  |   |  |   |  |  |   |
|---|--|--|--|---|--|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>LuberTha</b>   |  |  | 2a. DATE OF DEATH<br>MONTH <b>1</b> DAY <b>02</b> YEAR <b>82</b>       |   |  | 2b. HOUR<br><b>1:35</b> AM  |  |  |   |
| 3. SEX<br><b>F</b>  |  | 4. RACE<br><b>B</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>7</b> DAY <b>06</b> YEAR <b>25</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>56</b> YRS  |  | 7. IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN.  |   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>South Carolina</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balt. City</b> MD.                                   |  |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Balt.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Bon Secours Hosp</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>unemployed</b>           |  | 12b. KIND OF BUSINESS OR INDUSTRY  |   |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1719 Harlem Avenue</b>   |   |
| 14. FATHER'S NAME<br>FIRST <b>John</b> MIDDLE <b>Lincoln</b> LAST <b>Lincoln</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Fannie</b> MIDDLE <b>Lou</b> LAST <b>Lincoln</b>   |  |   |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b> (IF YES, GIVE WAR OR DATES)  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>215-07-9099</b>  |  | 17. INFORMANT<br>ADDRESS <b>Louise Singletary 1719 Harlem Ave.</b>                              |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO-PULMONARY ARREST</b><br><b>2859</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>RENAL FAILURE</b><br>(b) <b>GENERALIZED ANASARCA</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>MALNUTRITION; MULTIPLE SCLEROSIS</b><br>(c) <b>SEVERE PROFOUND ANEMIA</b> |  |  |  |   |  |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>AS ABOVE</b>  |  |  |  |   |  |   |  |  |   |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |   |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |  |  |   |
| 22a. I certify that on this hospital attended the deceased from <b>12/27</b> 19 <b>81</b> to <b>1/2</b> 19 <b>82</b> , that <b>(we)</b> last saw the deceased alive on <b>1/2</b> 19 <b>82</b> , and that in <b>(our)</b> opinion death occurred on the date and hour and from the causes stated above. <b>(we)</b> <b>(did not)</b> view the body after death.                         |  |  |  |   |  |   |  |  |   |
| 22b. SIGNATURE<br><b>Howard B. Chen, M.D.</b>   |  |  |  |   |  | DEGREE<br><b>M.D.</b>   |  | 22c. DATE SIGNED<br><b>1/2/82</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HOWARD B. CHEN, M.D.</b>  |  |  |  |   |  | 22e. ADDRESS<br><b>BON SECOURS HOSPITAL</b>   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>1/7/82</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview Mem. Pk.</b>                 |   | 23d. LOCATION<br>CITY OR TOWN <b>Catonsville, Md.</b> COUNTY STATE |  |   |
| 24. FUNERAL DIRECTOR<br><b>Wm C March F/H 1101 E. North Ave.</b>  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 5 1982</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>James J. Van Patten</b>   |   |



JAN 2 1965

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   | 8 2 0 1 2 0 2 |   |  |  |  |
|--|--|---|--|---|---------------|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   | REG. NO.   |   |               |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>DR. HARRY LINDEN  |  |   | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>January 22 1982                  |   |               | 3. HOUR<br>10:30 AM   |  |  |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>MAY 24, 1887  |               | 6. AGE (IN YEARS LAST BIRTHDAY)<br>94 YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>RUSSIA  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |               | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>14 S. BROADWAY |  |   |               | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>GEN. PHYSICIAN              |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>MEDICAL   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MARYLAND   |  | 13b. COUNTY<br>BALTIMORE  |  | 13c. CITY OR TOWN<br>BALTIMORE  |               | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>14 S. BROADWAY #21231   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>ABRAHAM LINDEN   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>RACHEL MINDEL UNKNOWN |   |               |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br>219-52-4850   |  | 17. INFORMANT<br>:MRS. GRACE R. LINDEN  |               | 18. ADDRESS<br>14 S. BROADWAY BALTO., MD 21231  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION<br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)                     |  |   |  |   |               |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>20 min.<br>20 yrs.   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br>SENILE DEMENTIA   |  |   |  |   |               |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |               | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |               |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |               |   |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from 12/15, 1974, to Jan 22, 1982, that (I) (we) lost saw the deceased alive on Nov 9, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |  |   |  |   |               |   |  |  |  |
| 22b. SIGNATURE<br>Charles O. Donovan   |  |   |  | DEGREE<br>MD  |               |   |  | 22c. DATE SIGNED<br>Jan 22, 1982   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>CHARLES O. DONOVAN  |  |   |  | 22e. ADDRESS<br>9 E. CHASE ST BALTIMORE, MD 21202   |               |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  | 23b. DATE<br>JAN. 24, 1982  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>HEBREW YOUNG MEN  |               | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MARYLAND                                |  |  |  |
| 24. FUNERAL DIRECTOR<br>Sol Levison 1200 6010 Reisterstown Rd.   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 27 1982  |               | 25b. REGISTRAR'S SIGNATURE<br>Charles O. Donovan  |  |  |  |

1-1-1917

17th St. S.W. Washington



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |  |  |
|---|--|--|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 8-2 01203  |  |   |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST MIDDLE LAST<br>LANA M. LINDER  |  |   |  | 2a. DATE OF DEATH  |  | MONTH DAY YEAR<br>1 14 82                              |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>July 26, 1908   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>73 YRS.   |  | 2b. HOUR<br>4:45 P.M.                                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Iowa   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                           |  | 9. BALTIMORE MD. COUNTY OF DEATH<br>Baltimore City   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home          |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(GIVE FULL STREET ADDRESS)<br>UNION MEMORIAL HOSPITAL |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker  |  |  |  |
| 13a. STATE<br>Iowa  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Oelwein  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                       |  | 13e. STREET ADDRESS<br>Route 1                         |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>James V. Mohler   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Cora Gager  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>708 10 0455  |  | 17. INFORMANT ADDRESS<br>David V. McQueen, Balto., Md. |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4/100 MYOCARDIAL INFARCTION<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____ |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>24 hours   |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>CONGESTIVE HEART FAILURE AND CARDIOGENIC SHOCK |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from 1-13, 1982, to 1-14, 1982, that (1) (we) last saw the deceased alive on 1-14, 1982, and that in my (1) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) did not view the body after death.   |  | 22b. SIGNATURE<br>J. A. Townsend MD  |  | 22c. DATE SIGNED<br>1-14-82   |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>FRANCIS JAMES TOWNSEND   |  | 22e. ADDRESS<br>201 E. University Pkway  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Removal  |  | 23b. DATE<br>1/18/82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Woodlawn Cemetery   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Oelwein, Iowa  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Henry W. Jenkins & Sons Co.   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 18 1982   |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |  |  |
| 4905 York Road Balto., Md. 21212  |  |  |  |   |  |  |  |  |  |

1 M 2 4 4

NUMBER

DATE

July 22, 1908

Wife

Frank

Wm. W. Smith  
Hingham City

Wm. W. Smith  
Hingham City

Wm. W. Smith  
Hingham City

Wm. W. Smith  
Hingham City

Frank

Wm. W. Smith

Wm. W. Smith

Wm. W. Smith

Wm. W. Smith

Wm. W. Smith

Wm. W. Smith

Wm. W. Smith

Wm. W. Smith, Hingham City, Mass.

Wm. W. Smith

Wm. W. Smith

Wm. W. Smith, Hingham City, Mass.

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Wm. W. Smith, Hingham City, Mass.

Wm. W. Smith

Wm. W. Smith, Hingham City, Mass.

Wm. W. Smith, Hingham City, Mass.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 7a g564 2/17/82 gj

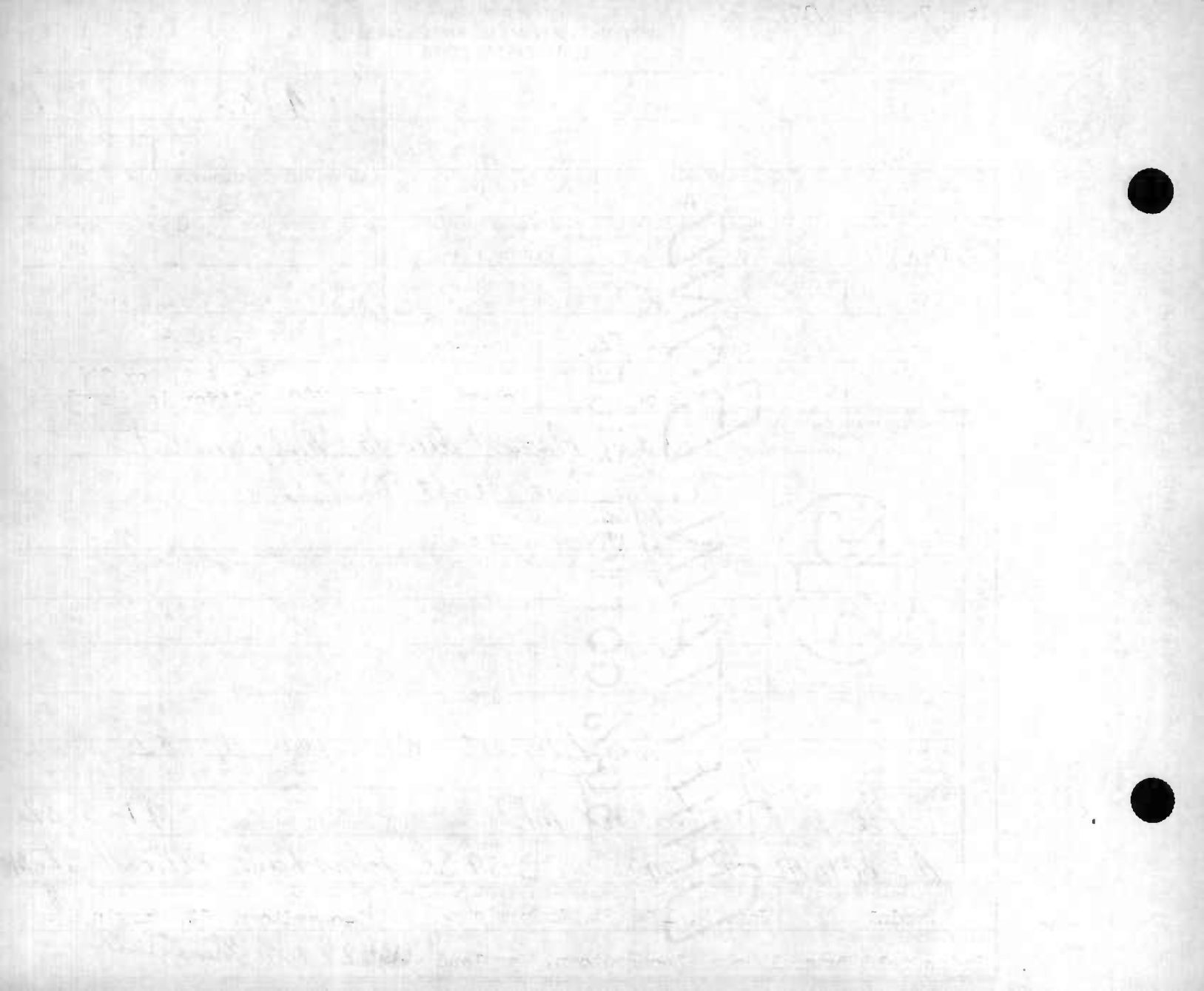
FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 2 0 4

REG. NO.

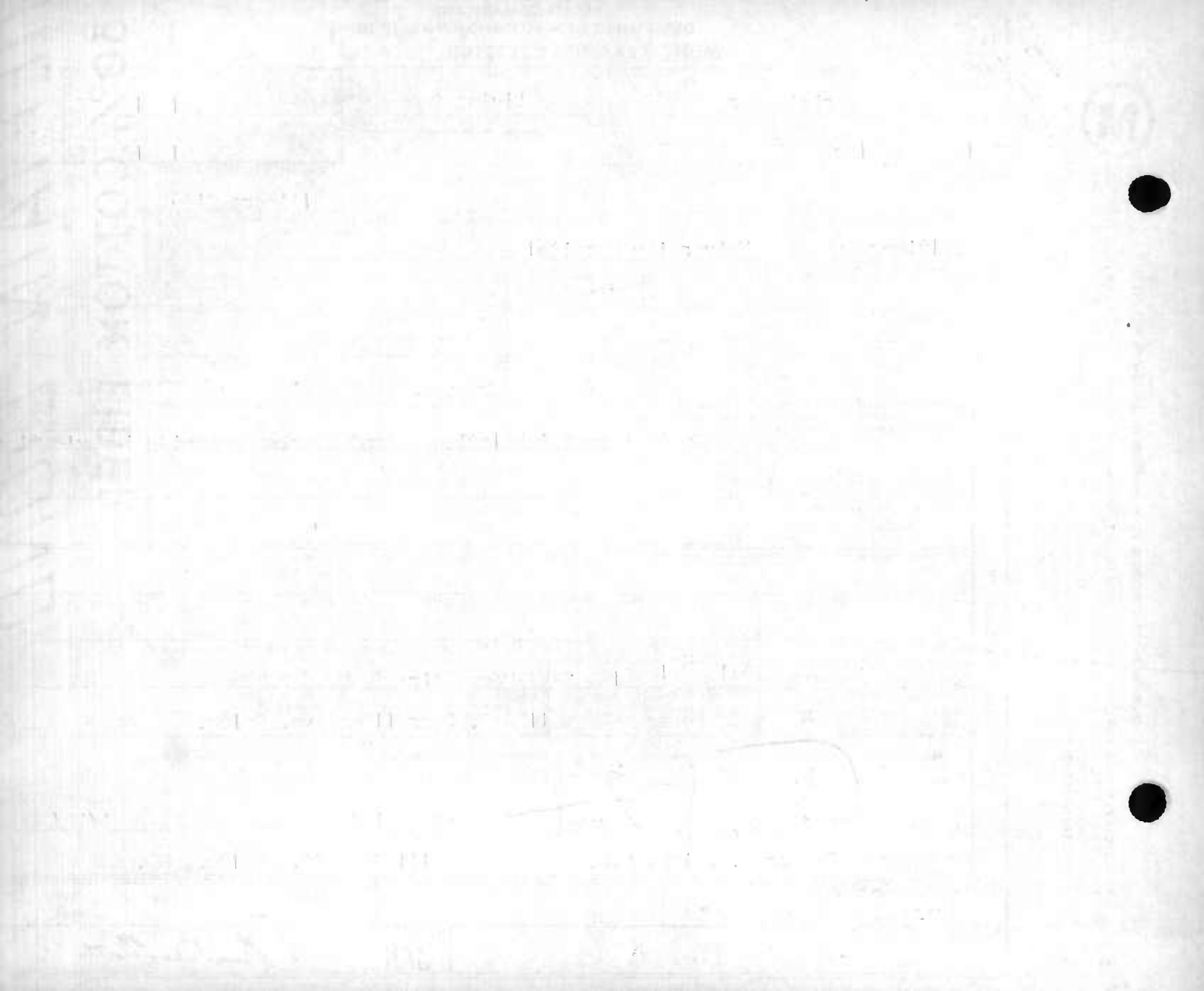
|  |   |   |   |   |  |
|--|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>CHARLES LIVINGSTON  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1/4/82   |   | 2b. HOUR<br>10:09 PM   |
| 3. SEX<br>M  | 4. RACE<br>W  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11 9 00   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>81   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>11   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>City MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTO   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore Hosp |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |   | 12b. KIND OF BUSINESS OR INDUSTRY  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |   |   |   |   |  |
| 13a. STATE<br>MD   | 13b. COUNTY   | 13c. CITY OR TOWN<br>BALTO  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>1217 W. FAYETTE ST   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles B. Livingston, Sr.   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Carrie Pritzel                                 |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |   | 16b. SOCIAL SECURITY NO.<br>Unknown   |   | 17. INFORMANT<br>ADDRESS<br>Robert B. Livingston Rt. # 2, Box 206<br>California, Maryland |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4100 Cardiac Arrest due to M.I., recurrent<br>DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure<br>DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension                  |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |   |   |   |   |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from August 81 to Jan 4, 1982, that (I) (we) last saw the deceased alive on Jan 4, 1982 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |   |   |   |  |
| 22b. SIGNATURE<br>A.I. Baykaler, MD  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |   | 22c. DATE SIGNED<br>1-5-82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>A.I. BAYKALER, MD.  |   | 22e. ADDRESS<br>3459 St. Johns Lane Ellicott City, MD   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |   | 23b. DATE<br>Jan. 8, 1982   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>St. Andrew's  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Leonardtown St. Mary's Md.   |   | 23e. DATE REC'D. BY REGISTRAR<br>JAN 22 1982  |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Brinsfield Funeral Home  |   | ADDRESS<br>Leonardtown, Maryland  |   |   |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |               |   |   |  |  |  |  |  |  | REG. NO. 8 2 0 1 2 0 5 |  |
|--|---------------|---|---|--|--|--|--|--|--|------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) Christopher Livingston   |               |   |   |  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 1 18 19 82        |  | 2b. HOUR M 4:15P   |  |                        |  |
| 3. SEX Male  | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR 7 25 78   | 6. AGE (IN YEARS LAST BIRTHDAY) 3 YRS.                            | IF UNDER 1 YR. MONTHS DAYS   | IF UNDER 24 HRS. HOURS MIN.  | 7c. DATE PRONOUNCED DEAD 1 18 19 82  |  | 7d. HOUR M 4:15P   |  |                        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD   |               | 7b. CITIZEN OF WHAT COUNTRY? USA  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.                                     |  |  |  |                        |  |
| 10. CITY OR TOWN OF DEATH Baltimore  |               | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital |   |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                        |  |
| 13a. STATE MD  |               | 13b. COUNTY   |   | 13c. CITY OR TOWN Baltimore  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS 1155 N. Carrollton Ave.                                      |  |                        |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST Bernard Livingston   |               |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sharon Ballard  |  |  |  |  |  |                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No  |               | 16b. SOCIAL SECURITY NO. N/A  |   | 17. INFORMANT ADDRESS Sharon Livingston 1155 Carrollton  |  |  |  |  |  |                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Smoke &amp; soot inhalation &amp; Acute carbon monoxide intoxication</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |               |   |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                        |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |               |   |   |  |  |  |  |  |  |                        |  |
| 19a. DATE OF OPERATION   |               |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                 |  |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                        |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |               |   | 21b. TIME OF INJURY HOUR MIN. MONTH DAY YEAR 3:15 P.M. 1 18 19 82 |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) House fire |  |  |  |  |                        |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |               |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) house |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1155 N. Carrollton Ave. Balto. Md         |  |  |  |  |                        |  |
| 22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |               |   |   |  |  |  |  |  |  |                        |  |
| ACTUAL SIGNATURE   |               |   | TITLE (SPECIFY) M.D. Deputy Chief                                 |  |  | MEDICAL EXAMINER   |  | DATE SIGNED 1/19/82  |  |                        |  |
| EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.  |               |   | ADDRESS 111 Penn St. Balto., MD.                                  |  |  |  |  |  |  |                        |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial   |               |   | 23b. DATE 1/23/82   |  | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.                                       |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co. MD |  |  |                        |  |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/H   |               |   |   |  | ADDRESS 1101 E. North Ave.   |  | 25a. DATE REC'D. BY REGISTRAR JAN 21 1982                |  | 25b. REGISTRAR'S SIGNATURE                   |                        |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                  |  |   |  |   |  |  |  | REG. NO. 5 2 0 1 2 0 6                                      |  |   |  |
|--|--|------------------|--|---|--|---|--|--|--|---|--|---|--|
| 1- FOR STATE REGISTRAR   |  |                  |  |   |  |   |  |  |  | 20. DATE KNOWN OF DEATH                                     |  | 21. HOUR  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Willie S. Lloyd  |  |                  |  |   |  |   |  |  |  | XX 1 16 19 82   |  | M   |  |
| 3. SEX<br>Male   |  | 4. RACE<br>Black |  | 5. DATE OF BIRTH (MONTH DAY YEAR)<br>4 4 59   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>22 YRS.                  |  | IF UNDER 1 YR. MONTHS DAYS   |  | 7c. DATE PRONOUNCED DEAD<br>1 16 19 82                      |  | 2d. HOUR<br>2:25 A.M.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>N.C.  |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                         |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>770 W. Saratoga Street |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br>MD   |  |                  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore                              |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br>221 N. Fremont Avenue                |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>—   |  |                  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Leatha Lloyd  |  |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br>No   |  |                  |  | 16b. SOCIAL SECURITY NO.<br>N/A   |  | 17. INFORMANT ADDRESS<br>Leatha Lloyd 221 N. Fremont Avenue |  |  |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 9634 Multiple gunshot Wounds<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |                  |  |   |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                  |  |   |  |   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |  |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>2:20 PM 1 16 19 82  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>subject was shot  |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>building   |  |   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br>770 W. Saratoga St., Baltimore, Maryland   |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |                  |  |   |  |   |  |  |  |   |  |   |  |
| ACTUAL SIGNATURE<br>Virginia L. Dolan  |  |                  |  | TITLE (SPECIFY)<br>M.D. Assistant   |  |   |  | MEDICAL EXAMINER   |  |   |  | DATE SIGNED<br>1-16-82  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Virginia L. Dolan, M.D.   |  |                  |  | ADDRESS<br>111 Penn Street  |  |   |  |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |                  |  | 23b. DATE<br>1/22/82  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview Mem. Pk.     |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore Co. MD |  |   |  |
| 24. FUNERAL DIRECTOR NAME<br>Wm. C. March F/H  |  |                  |  | ADDRESS<br>1101 E. North Ave.   |  |   |  | 25b. DATE REC'D. BY REGISTRAR<br>JAN 19 1982   |  |   |  |   |  |



100% COLUMBIAN SHEET  
100% COLUMBIAN SHEET  
100% COLUMBIAN SHEET

James H. H. H.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 2 0 7

FOR  
1. STATE  
REGISTRAR

REG. NO.

|   |   |   |  |  |  |
|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Agnes H. Long</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 10, 1982</b>   |  | 2b. HOUR<br>P.<br><b>9:30</b>  |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>July 27, 1914</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b>   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Baltimore, Md.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD.</b>                   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>731 N. Kenwood Avenue</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Machine Operator &amp; Inspector</b>  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Md. Cup</b>                                  |  |
| 13a. STATE<br><b>Md.</b>  |   |   | 13b. COUNTY<br><b>---</b>  | 13c. CITY OR TOWN<br><b>Baltimore</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>? ? Dembeck</b>  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Helen Trentler</b>   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>218-12-2496</b>  | 17. INFORMANT<br>ADDRESS<br><b>Baltimore, Md. 21205</b><br><b>Franklin W. Long-731 N. Kenwood Ave.</b>   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY ARREST.</b><br><b>1539</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>METASTATIC COLON CANCER.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Mild chronic renal failure; w/ MYOCARDIAL INFARCT.</b>   |   |   |  |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/1</b> , 19 <b>79</b> , to <b>1/10</b> , 19 <b>82</b> , that (b) (we) last saw the deceased alive on <b>1/5</b> , 19 <b>82</b> , and that in (c) (our) opinion death occurred on the date and hour and from the causes stated above. (d) (we) (did) (did not) view the body after death.   |   |   |  |  |  |
| 22b. SIGNATURE<br><b>John F. Pettigrew</b>  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1/11/82</b>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>John F. Pettigrew M.D.</b>  |   |   | 22e. ADDRESS<br><b>Johns Hopkins Oncology Center</b>   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |   | 23b. DATE<br><b>1/13/82</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b>  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>John F. Moran, Inc.</b><br><b>3000 E. Baltimore St.</b>  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 18 1982</b>  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8 2 0 1 2 0 8   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>FREDERICK LONG</b>  |  |   |  | 2a. DATE OF DEATH<br>MONTH <b>1</b> DAY <b>4</b> YEAR <b>82</b>   |  |  |  |
| 3. SEX<br><b>M</b>   |  | 4. RACE<br><b>B</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>12</b> DAY <b>17</b> YEAR <b>12</b>  |  | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>67</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>S. Carolina</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>City</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Lutheran Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE <b>MD</b>   |  |   |  | 13b. COUNTY <b>Balto</b>  |  | 13c. CITY OR TOWN <b>Balto</b>   |  |
| 14. FATHER'S NAME<br>FIRST <b>Henry</b> MIDDLE <b>Long</b> LAST <b>Long</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Carrie</b> MIDDLE <b>Copeland</b> LAST <b>Copeland</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>213-80-9631</b>  |  | 17. INFORMANT<br><b>Edward Copeland</b>   |  | ADDRESS <b>3319 Brighton St. Balto., Md. 21216</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiorespiratory Arrest.</b><br><b>2762</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Refactory Metabolic Acidosis.</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>2 days</b>  |  |   |  |   |  | APPROPRIATE INTERVAL BETWEEN ORGEL AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>DIC, SEPSIS</b>   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/18</b> , 19 <b>81</b> , to <b>1/4</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>1/4</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (I) (did not) view the body after death. |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Michael H. Glone</b>  |  |   |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>1/4/82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Michael H. Glone</b>   |  |   |  | 22e. ADDRESS<br><b>Lutheran Hospital</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Removal</b>  |  | 23b. DATE<br><b>1/7/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Anatomy Board</b> ADDRESS <b>Balto., Md.</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 12 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>James J. [Signature]</b>  |  |

Author: E. Corcoran

Title:

Genre:

Length:

Series:

Copyright:

312 1/2 inches

212-00-0000

Edward Corcoran

212-00-0000

12/7/02

Received

Author: E. Corcoran

Title:

Genre:

Copyright:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |   |  | REG. NO.   |  |
|--|--|---|--|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  |   |  |  |  |   |  | 8201209  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>GRACE L. LONG  |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1 1 82                                  |  | 2b. HOUR<br>12:30 AM  |  |  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>6 19 1897   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>84 YRS.                                     |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                     |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>607 E. 37th Street |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home   |  |  |  |
| 13a. STATE<br>Maryland   |  |   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>607 E. 37th St. 21218   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Edward B. Keelen   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Funk  |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No   |  |   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br>ADDRESS<br>Edward C. Long 607 E. 37th St.                     |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u><br>4140<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Artery disease</u><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>minutes</u>              |  |   |  |   |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/1</u> , 19 <u>82</u> , to <u>1/1</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>1/1/82</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Dr. Mark Dugan</u>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |  |  | 22c. DATE SIGNED<br><u>1/5/82</u>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Mark Dugan  |  |   |  | 22e. ADDRESS<br><u>15 E. Biddle St Baltimore Md 21202</u>   |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |   |  | 23b. DATE<br>1-4-82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood                                 |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Parkville Balto. Md.                              |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Henry W. Jenkins & Sons  |  |   |  | ADDRESS<br>4905 York Rd<br>Balto. 21212   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 4 1982                                    |  | 25b. REGISTRAR'S SIGNATURE<br><u>James J. North</u>   |  |  |  |





BP

DHMM - 16 50M 1/81  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |   |  |   |  |  |   |  |
|---|--|--|--|---|--|---|--|--|---|--|
| 1 - FOR STATE REGISTRAR   |  |  |  |   | 8 2 0 1 2 1 0  |   |  |  |   |  |
| CERTIFICATE OF DEATH  |  |  |  |   | REG. NO.   |   |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>HERBERT R. LONG  |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>JANUARY 15, 1982                   |   |  | 2b. HOUR<br>6 47 AM  |   |  |
| 3. SEX<br>MALE  |  | 4. RACE<br>NEGRO   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>APRIL 16 1907   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS.                                    |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>VIRGINIA   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                    |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNIVERSITY HOSPITAL |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>LABORER   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>BETH STEEL  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MARYLAND   |  |  |  |   | 13b. COUNTY  |   | 13c. CITY OR TOWN<br>BALTIMORE                                     |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>ROBERT LONG   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>NANCY CROWLEY         |   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  |  |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>217-14-2775 |   | 17. INFORMANT ADDRESS<br>Johnny Long/5731 Simmonds Ave 21215       |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardio pulmonary Arrest</u><br>4275<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Massive hemoptysis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>30 min</u><br><u>unknown</u> |  |  |  |   |  |   |  |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |   |  |  |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>     |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/15</u> , 19 <u>82</u> , to <u>1/15/82</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>1/15</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |  |   |  |
| 22b. SIGNATURE<br>Robert H. Galtman<br>DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>   |  |  |  |   |  | 22c. DATE SIGNED<br>1/15/82   |  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Robert Levitt  |  |  |  |   |  | 22e. ADDRESS<br>University Hospital   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  |  | 23b. DATE<br>01/20/82  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>WESTVIEW MEM PARK                |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>CATONSVILLE BALTO MD |  |   |  |
| 24. FUNERAL DIRECTOR<br>MARSHALL W JONES, JR/4101   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 19 1982                                  |  |  |   |  |
| 25b. REGISTRAR'S SIGNATURE<br>James J. Nathan   |  |  |  |   |  |   |  |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be completed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in the funeral director's page 3 should be detached for use as the burial transit permit. Then please remove card 3 from page 3 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |                   |   |  |  |  | 8 2 0 1 2 1 1  |  |  |  |          |  |   |  |
|---|--|---|--|---|-------------------|---|--|--|--|--|--|--|--|----------|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | REG. NO.  |  |   |                   |   |  |  |  |  |  |  |  |          |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   |  |   | 2a. DATE OF DEATH |   |  | MONTH  |  | DAY  |  | YEAR   |  | 2b. HOUR |  |   |  |
| PRESTON Adams LONG  |  |   |  |   | JANUARY 20, 1982  |   |  |  |  |  |  |  |  | 11:57A   |  |   |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |                   | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS  |  |  |  |          |  |   |  |
| Male  |  | White   |  | MONTH DAY YEAR<br>1 25 99   |                   | 82  |  | MONTHS   |  | DAYS   |  | HOURS  |  | MIN.     |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.          |  |  |  |  |  |  |  |          |  |   |  |
| Maryland  |  | U.S.A.  |  |   |                   |   |  |  |  |  |  |  |  |          |  |   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |                   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)    |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |  |  |          |  |   |  |
| Baltimore   |  | JOHNS HOPKINS HOSPITAL  |  |   |                   | Retired   |  |  |  | Penn. R.R.   |  |  |  |          |  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |   |                   |   |  |  |  |  |  |  |  |          |  |   |  |
| 13a. STATE  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |                   | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS  |  |  |  |  |  |          |  |   |  |
| Maryland  |  |   |  | Baltimore   |                   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 811 S. Eaton Street 21224  |  |  |  |  |  |          |  |   |  |
| 14. FATHER'S NAME   |  |   |  | 15. MOTHER'S MAIDEN NAME  |                   |   |  |  |  |  |  |  |  |          |  |   |  |
| FIRST MIDDLE LAST<br>Sidney Long  |  |   |  | FIRST MIDDLE LAST<br>Stella Adams   |                   |   |  |  |  |  |  |  |  |          |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  |  |   |  | 16b. SOCIAL SECURITY NO.  |                   |   |  | 17. INFORMANT ADDRESS  |  |  |  |  |  |          |  |   |  |
| No  |  |   |  | 717-07-8684   |                   |   |  | Melvin S. Long 811 South Eaton Street 21224                                    |  |  |  |  |  |          |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u><br>4413<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial Infarction</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Ruptured Abdominal Aortic Aneurysm</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>40 min<br>5 days<br>5 days |  |   |  |   |                   |   |  |  |  |  |  |  |  |          |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |                   |   |  |  |  |  |  |  |  |          |  |   |  |
| MEDICAL CERTIFICATION   |  |   |  |   |                   |   |  |  |  |  |  |  |  |          |  |   |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                   |   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |  |          |  |   |  |
| 1-14-82   |  |   |  | Ruptured Abdominal Aortic Aneurysm  |                   |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |  |  |          |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                   |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |  |  |          |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                   |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |  |  |          |  |   |  |
|   |  |   |  |   |                   |   |  |  |  |  |  |  |  |          |  |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from 1/11 to 1/20, 1982, to 1/20, 1982. The (1) (we) last saw the deceased alive on 1/20, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.  |  |   |  |   |                   |   |  |  |  |  |  |  |  |          |  |   |  |
| 22b. SIGNATURE<br>Charles D. Cousar   |  |   |  | DEGREE<br>MD  |                   |   |  | 22c. DATE SIGNED<br>1/20/82  |  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |          |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>C.D. COUSAR  |  |   |  | 22e. ADDRESS<br>JOHNS HOPKINS HOSPITAL  |                   |   |  |  |  |  |  |  |  |          |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  |   |  | 23b. DATE   |                   | 23c. NAME OF CEMETERY OR CREMATORY                                  |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                     |  |  |  |          |  |   |  |
| Burial  |  |   |  | 1-23-82   |                   | Sacred Heart Cemetery   |  |  |  | Dundalk, Balto. Co. Md.  |  |  |  |          |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>C.S. Zeiler & Son Inc. 6224 Eastern Avenue  |  |   |  |   |                   |   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 21 1982                   |  |  |  |          |  | 25b. REGISTRAR'S SIGNATURE<br>Thomas Jan Nathan |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| FOR STATE REGISTRAR  |  |  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 2 0 1 2 1 2<br>REG. NO.  |  |  |  |
|--|--|--|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>SALLIE LONG</b>  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JANUARY 25, 1982</b>  |  |   |  | 2b. HOUR<br><b>9:00PM</b>  |  |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 15 13</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>0 0</b>   |  | IF UNDER 24 HRS<br>HOURS MIN.<br><b>0 0</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>S.C.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b>  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1104 E. Preston St.</b>                                    |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Willie Thompson</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Esther</b>  |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>216-30-8685</b>  |  | 17. INFORMANT ADDRESS<br><b>Almetter Mosley Kannapolis, N.C.</b>                                |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiac arrest</b><br><b>1830</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>metastatic ovarian cancer</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |  |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>1/5</b> , 19 <b>82</b> , to <b>1/25</b> , 19 <b>82</b> , that (1) (we) lost <b>saw the deceased alive on 1/25</b> , 19 <b>82</b> , and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.                          |  |  |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Robert I. Garver, Jr.</b>   |  |  |  |   |  | DEGREE  |  | 22c. DATE SIGNED<br><b>1/25/82</b>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ROBERT I. GARVER, JR.</b>  |  |  |  |   |  | 22e. ADDRESS<br><b>DEPT. OF MED<br/>JOHNS HOPKINS HOSPITAL</b>                                  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>1/30/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Auburn Cem.</b>  |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore MD</b>                    |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H</b>  |  |  |  |   |  | ADDRESS<br><b>1101 E. North Ave.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 28 1982</b>                                  |  |  |  |
|  |  |  |  |   |  |   |  | REGISTRAR'S SIGNATURE<br><b>James J. [Signature]</b>                                 |  |  |  |

UNITED STATES DEPARTMENT OF AGRICULTURE

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U.S. DEPT. OF AGRICULTURE  
WASHINGTON, D.C.



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**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO. 2 0 1 2 1 3

|  |  |               |  |  |  |   |  |  |  |  |  |   |  |  |  |   |  |  |  |                   |  |
|--|--|---------------|--|--|--|---|--|--|--|--|--|---|--|--|--|---|--|--|--|-------------------|--|
| 1. FOR STATE REGISTRAR   |  |               |  |  |  |   |  |  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 1 19 1982 |  |   |  |  |  |   |  |  |  | 2b. HOUR M 0      |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>Bobbie L. Love</b>                 |  |               |  |  |  |   |  |  |  | 2c. DATE PRONOUNCED DEAD 1 19 1982   |  |   |  |  |  |   |  |  |  | 2d. HOUR a M 6:31 |  |
| 3. SEX Male  |  | 4. RACE Negro |  | 5. DATE OF BIRTH MONTH DAY YEAR Feb 8 1928   |  | 6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS. |  | IF UNDER 1 YR. MONTHS DAYS   |  | IF UNDER 24 HRS. HOURS MIN   |  |   |  |  |  |   |  |  |  |                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mississippi                  |  |               |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.  |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.                     |  |  |  |   |  |  |  |                   |  |
| 10. CITY OR TOWN OF DEATH Baltimore                                    |  |               |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 317 N. Paca Street |  |   |  |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Business Mgr. |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY Local #194      |  |  |  |                   |  |
| 13a. STATE Maryland  |  |               |  |  |  |   |  |  |  | 13b. COUNTY Balto  |  | 13c. CITY OR TOWN Baltimore   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS 21228 6609 Hunterswood Circle |  |  |  |                   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST Robert Love                        |  |               |  |  |  |   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ethel Steele                              |  |   |  |  |  |   |  |  |  |                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES |  |               |  |  |  |   |  |  |  | 16b. SOCIAL SECURITY NO. Korean 216-30-5673  |  | 17. INFORMANT ADDRESS Minnie J. Love/6609 Hunterswood Cir                   |  |  |  |   |  |  |  |                   |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>9654 IMMEDIATE CAUSE (a) Multiple gunshot wounds<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|

|  |  |  |  |  |  |  |  |  |  |                     |  |  |  |       |  |
|--|--|--|--|--|--|--|--|--|--|---------------------|--|--|--|-------|--|
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |  |  |  |  |                     |  |  |  |       |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                      |  |  |  |  |  |                     |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |       |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 5:45 PM 1 19 1982         |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject shot |  |                     |  |  |  |       |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) union hall |  |  |  | 21f. LOCATION STREET 317 N. Paca St.   |  | CITY OR TOWN Balto. |  | COUNTY Md.   |  | STATE |  |
| 22a. I certify that I took charge of the remains described above, held a death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |  |  |  |  |  |  |                     |  |  |  |       |  |
| ACTUAL SIGNATURE <i>Thomas D. Smith</i>  |  |  |  | TITLE (SPECIFY) Deputy Chief   |  |  |  | MEDICAL EXAMINER   |  |                     |  | DATE SIGNED 1/19/82  |  |       |  |
| EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.  |  |  |  | ADDRESS 111 Penn St. Balto., Md.                                       |  |  |  |  |  |                     |  |  |  |       |  |

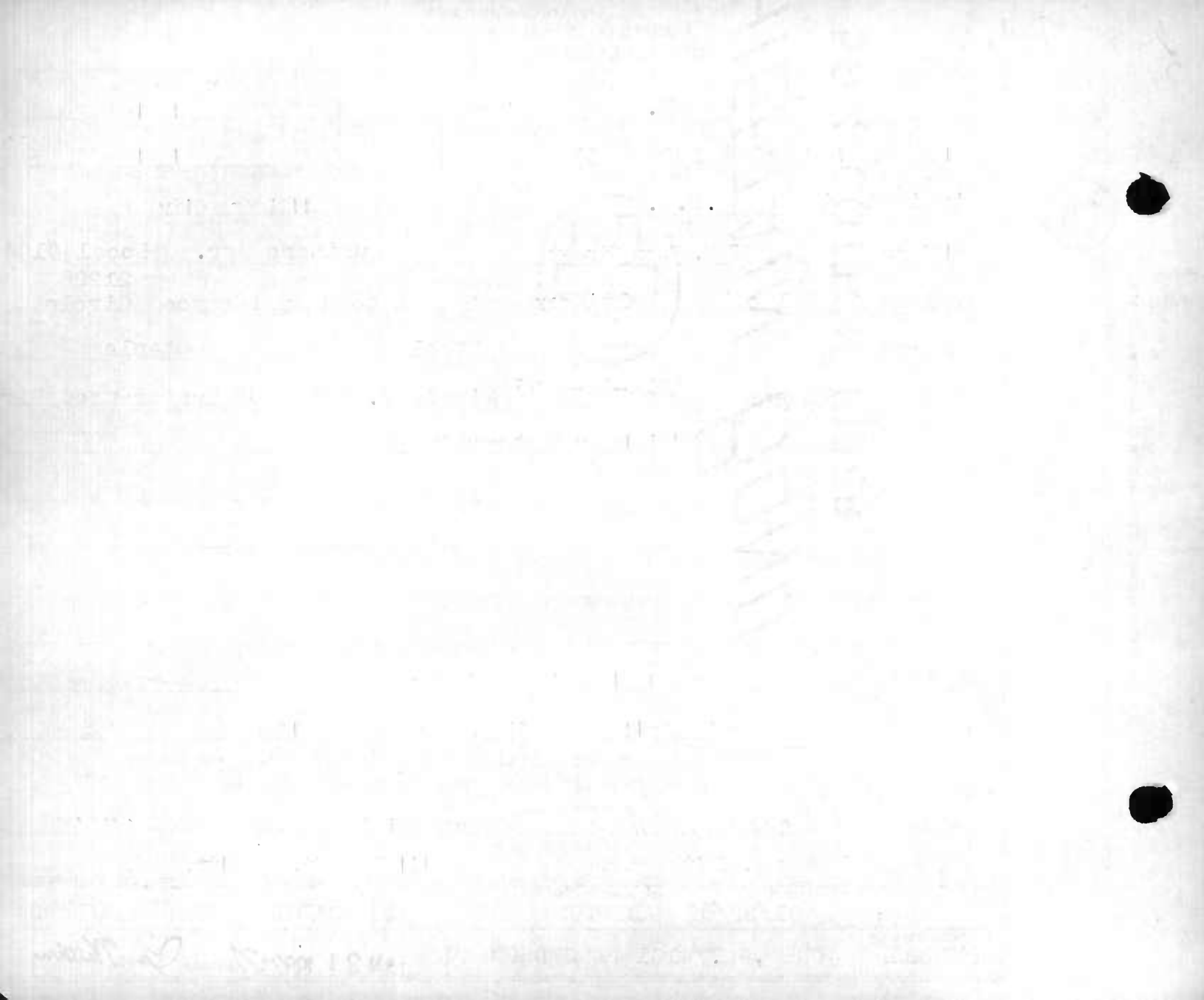
|  |  |                    |  |  |  |  |  |  |  |  |  |  |  |
|--|--|--------------------|--|--|--|--|--|--|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial                     |  | 23b. DATE 01/22/82 |  | 23c. NAME OF CEMETERY OR CREMATORY ARBUTUS MEMORIAL PK |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE ARBUTUS BALTO MARYLAND |  |  |  |  |  |
| 24. FUNERAL DIRECTOR MARSHALL W JONES, JR. ADDRESS 4101 EDMONDSON AV |  |                    |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR JAN 21 1982                      |  | 25b. REGISTRAR'S SIGNATURE <i>Frances Van Natten</i> |  |  |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY BELIEVE THE DEATH IS SUSPICIOUS, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE 172 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD, 21201

0000 BP  
DHMH-17  
(VRA15 ME (1))  
15M 2/80





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 2 1 4

|  |         |  |                                 |  |  |
|--|---------|--|---------------------------------|--|--|
| 1. FOR STATE REGISTRAR   |         | 2a. DATE OF DEATH  |                                 | 2b. HOUR   |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |         | 2a. DATE OF DEATH  |                                 | 2b. HOUR   |  |
| FIRST MIDDLE LAST  |         | MONTH DAY YEAR   |                                 | M  |  |
| Dorothea R Lowman  |         | 01 29 82   |                                 | 9:00P  |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY) | 7. IF UNDER 1 YEAR   |  |
| F  | W       | MONTH DAY YEAR   | 67                              | MONTHS DAYS HOURS MIN.   |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |         | 9. BALTIMORE CITY OR COUNTY OF DEATH   |                                 | 10. CITY OR TOWN OF DEATH  |  |
| Maryland   |         | Baltimore City   |                                 | Baltimore  |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)   |         | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |                                 | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| St. Agnes Hospital   |         | Secretary  |                                 | Cannon Shoe Co.  |  |
| 13a. STATE   |         | 13b. CITY OR TOWN  |                                 | 13c. INSIDE CITY LIMITS?   |  |
| Maryland   |         | Baltimore  |                                 | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 14. FATHER'S NAME  |         | 15. MOTHER'S MAIDEN NAME   |                                 | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?   |  |
| FIRST MIDDLE LAST  |         | FIRST MIDDLE LAST  |                                 | (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)   |  |
| Lawrence Milan   |         | Katharine Rosasco  |                                 | NO   |  |
| 17. INFORMANT  |         | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1629 |                                 | 19. SOCIAL SECURITY NO.  |  |
| Alan L. Lowman   |         | Poorly Differentiated Squamous Carcinoma of lung   |                                 | 215-14-9297  |  |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                 | 20a. AUTOPSY?  |  |
|  |         |  |                                 | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |         | 21b. TIME OF INJURY  |                                 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |
|  |         | HOUR A.M. MONTH DAY YEAR   |                                 |  |  |
|  |         | P.M. 19  |                                 |  |  |
| 21d. INJURY OCCURRED   |         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                                 | 21f. LOCATION  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |         |  |                                 | STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-29, 19 82, to 1-29, 19 82, that (I) (we) last saw the deceased alive on 1-29, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |         | 22b. SIGNATURE   |                                 | 22c. DATE SIGNED   |  |
|  |         | Laurence Zeidner MD  |                                 | 1-29-82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |         | 22e. ADDRESS   |                                 | 22f. DEGREE  |  |
| Lawrence Zeidner, MD.  |         | St. Agnes Hospital   |                                 | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |         | 23b. DATE  |                                 | 23c. NAME OF CEMETERY OR CREMATORY   |  |
| Burial   |         | 2/3/82   |                                 | New Cathedral Cem.   |  |
| 24. FUNERAL DIRECTOR   |         | 25a. DATE REC'D. BY REGISTRAR  |                                 | 25b. REGISTRAR'S SIGNATURE   |  |
| NAME ADDRESS   |         | FEB 3 1982   |                                 | Name Jan 1982  |  |
| Hubbard Funeral Home, Inc. 4107 Wilkens Ave.   |         |  |                                 |  |  |



U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C. 20535  
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 2 1 5

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |  |
|---|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Lola Estelle Lowman</b>   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 10, 82</b>  |   | 2b. HOUR<br><b>8<sup>20</sup> A.M.</b>                             |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>July 25, 07</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b> YRS.                  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD.</b> |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Balt. Gen. Hosp.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Office Worker</b>        | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. Gov't.</b>            |
| 13a. STATE<br><b>Md.</b>  | 13b. COUNTY<br><b>A.A.</b>   | 13c. CITY OR TOWN<br><b>Brooklyn Pk.</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br><b>5351 Patrick Henry Dr.</b>               |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George E. Jeffrey</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN</b>   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b> |  | 16b. SOCIAL SECURITY NO.<br><b>213-22-2080</b>  |   | 17. INFORMANT (Daughter) ADDRESS<br><b>Mrs. Dorothy M. Storey</b>  |
|   |  |   |   | Same as # <b>13</b>  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Cardiac arrest**

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

**Severe peripheral vascular disease and ASCVD**

|   |   |  |   |
|---|---|--|---|
| 19a. DATE OF OPERATION<br><b>12/16/81</b>   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Gangrene of R foot</b> | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)        | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/16</b> 19 <b>81</b> to <b>1/10</b> 19 <b>82</b> , that (I) (we) lost<br>saw the deceased alive on <b>1/10</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |   |  |   |
| 22b. SIGNATURE<br><b>P. M. Johnson, M.D.</b>  |   | DEGREE<br><b>M.D.</b>  | 22c. DATE SIGNED<br><b>1/10/82</b>  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>P. M. Johnson</b>   |   | 22e. ADDRESS<br><b>3001 S. Hanover St.</b>                                     |   |

|  |   |   |  |
|--|---|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b> | 23b. DATE<br><b>13 Jan. 82</b>                      | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Security Proc. Inc., Catonsville, Balto, MD.</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE           |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Glen Burnie, Maryland</b>     | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 12 1982</b> |   | 25b. REGISTRAR'S SIGNATURE<br><b>James J. Nathan</b> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

BP

JAN 15 1985

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |  |  |
|--|--|---|--|---|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |   |  |   | 8 2 0 1 2 1 6<br>REG. NO.                                |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>VINCENT. LUCAS</b>  |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JAN. 20/82</b> |   |  | 2b. HOUR<br><b>6 57 A M</b>  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 19 03</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b> YRS.                         |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Puerto Rico</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.         |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BON SECOUR HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)          |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>1810 W. Lexington Street</b>                    |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>unkn</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Theresa -</b>   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>213-14-9874</b>  |  | 17. INFORMANT<br><b>Mary E. Lucas</b>   |  | ADDRESS<br><b>1810 W. Lexington St.</b>                                   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Septic shock</b><br><b>5850</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Cerebrovascular Accident</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Acute Renal failure</b> |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (16):<br><b>Mitral Insufficiency, Cancer of the colon, Congestive Heart failure</b>  |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>1/19/82</b>   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Colon Cancer</b>   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/19/82</b> to <b>1/20/82</b> , that (I) (we) lost<br>saw the deceased alive on <b>1/19/82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Bernardo D. Gonzales</b>  |  |   |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>1/20/82</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BERNARDO D. GONZALES</b>   |  |   |  | 22e. ADDRESS<br><b>BON SECOURS HOSP W. Fayette</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>1/25/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Calvary Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Anne Arundel Co. MD</b>  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H, Inc.</b>  |  |   |  | ADDRESS<br><b>1101 E. North Ave.</b>  |  | 25a. DATE RECD BY REGISTRAR<br><b>JAN 25 1982</b>                         |  | REGISTRAR'S SIGNATURE<br><b>Anne J. [Signature]</b>  |  |



*[Faint, illegible handwriting covering the page, possibly bleed-through from the reverse side.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 8 2 0 1 2 1 7   |  |  |  |
|---|--|--|--|---|--|--|--|
| FOR<br>STATE<br>REGISTRAR   |  |  |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>MARTIN C. LUDWIG SR.</b>   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>01 24 82</b>  |  | 2b. HOUR<br><b>10:24PM</b>   |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 18 05</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BON SECOURS HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SUPERVISOR</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>BRUSH FACTORY</b>  |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>---</b>  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 13e. STREET ADDRESS<br><b>452 S. BENTALOU STREET, 21223</b>   |  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ANTHONY LUDWIG</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARGARET SAHLENDER</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>213-10-8725</b>   |  | 17. INFORMANT<br><b>MARTIN C. LUDWIG, JR.</b>   |  | ADDRESS<br><b>452 S. BENTALOU ST.</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CARDIAC ARRHYTHMIAS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>SEVERE ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b>              |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Chronic Cerebral Atrophy; PARKINSON'S DISEASE</b>  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>April 25, 1979</b> , to <b>present</b> , 19____, that (I) (we) last saw the deceased alive on <b>OCT. 30, 1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>[Signature]</b>  |  | DEGREE<br><b>M.D.</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>1-25-82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>NORBERTO M. MACHIRAN, M.D.</b>  |  | 22e. ADDRESS<br><b>4713 LEEDS AVENUE; ARBUTUS, MD. 21227</b>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>01-28-82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LOUDON PARK</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE CITY MARYLAND</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>HUBBARD FUNERAL HOME, INC.</b>   |  | ADDRESS<br><b>4107 WILKENS AVE.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 27 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |



2

JAN 27 1985  
STANLEY J. LEE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |                        |  | 8 2 0 1 2 1 8                                |     |            |                    |
|---|--|--|--|--|--|---|--|------------------------|--|--|-----|------------|--------------------|
| 1. FOR STATE REGISTRAR  |  | REG. NO.   |  |  |  |   |  |                        |  |  |     |            |                    |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST  |  | MIDDLE   |  | LAST  |  | 2a. DATE OF DEATH      |  | MONTH  | DAY | YEAR       | 2b. HOUR           |
| HELMUT  |  | O.   |  | LUEDTKE  |  |   |  | 1/23/82                |  |  |     |            | 1:30A <sup>M</sup> |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR        |  | IF UNDER 24 HRS.                             |     |            |                    |
| Male  |  | White  |  | 9 MONTH 5 DAY 10 YEAR  |  | 71 YRS.   |  | MONTHS                 |  | DAYS   |     | HOURS MIN. |                    |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                        |  |  |     |            |                    |
| Germany   |  | German   |  |  |  | Baltimore City  |  |                        |  |  |     | MD.        |                    |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                        |  |  |     |            |                    |
| Baltimore   |  | St. Agnes Hospital   |  | Janitor  |  | Eastern Prod.   |  |                        |  |  |     |            |                    |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS    |  |  |     |            |                    |
| Maryland  |  | BALTE  |  | Baltimore  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 1011 Beechfield Avenue |  | 21229  |     |            |                    |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |   |  |                        |  |  |     |            |                    |
| Unknown   |  | Luedtke  |  | UNKNOWN  |  |   |  |                        |  |  |     |            |                    |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | ADDRESS   |  |                        |  |  |     |            |                    |
| NO  |  | 218-36-9719  |  | Kristina R. Ignatavicius   |  | 1011 Beechfield Ave   |  | 21229                  |  |  |     |            |                    |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cerebral infarct - bilateral</u><br>4349<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):<br><u>Sepsis 20 G UTI</u> |  |  |  |  |  |   |  |                        |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |     |            |                    |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |                        |  |  |     |            |                    |
| —   |  | —  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |                        |  |  |     |            |                    |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. — 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)   |  |   |  |                        |  |  |     |            |                    |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                 |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |                        |  |  |     |            |                    |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>01/22/82</u> 19 <u>82</u> , to <u>01/23/82</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>01/22/82</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  | 22b. SIGNATURE<br><u>Amare N. Sarwal M.D.</u>  |  | DEGREE<br>M.D.   |  | 22c. DATE SIGNED<br>1/23/82   |  |                        |  |  |     |            |                    |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>RAFAEL OLIVER  |  | 22e. ADDRESS<br>ST. Agnes Hospital<br>Baltimore  |  |  |  |   |  |                        |  |  |     |            |                    |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |  |                        |  |  |     |            |                    |
| Burial  |  | 1/26/82  |  | Meadowridge Mem. Park  |  | Elkridge  |  | Howard Co.             |  | Md.  |     |            |                    |
| 24. FUNERAL DIRECTOR<br>NAME  |  | 24b. ADDRESS   |  | 25a. DATE RECEIVED BY REGISTRAR  |  | REGISTRAR'S SIGNATURE   |  |                        |  |  |     |            |                    |
| Hubbard Funeral Home, Inc.  |  | 21229<br>4107 Wilkens Avenue   |  | JAN 25 1982  |  | Francis J. Martin   |  |                        |  |  |     |            |                    |

SECRET

UNITED STATES

DEPARTMENT OF THE ARMY

OFFICE OF THE ADJUTANT GENERAL

WASHINGTON, D. C.

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WASHINGTON, D. C.

ADJUTANT GENERAL

OFFICE OF THE ADJUTANT GENERAL

ADJUTANT GENERAL

## CERTIFICATE OF DEATH

REG. NO.

|   |   |   |   |   |                                   |
|---|---|---|---|---|-----------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>FREDERICK T LUPTON</b>  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 26 82</b>   |   | 2b. HOUR<br><b>10:00P</b>   |                                   |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 14 02</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> YRS  |                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Greenwood Va.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>CITY</b> MD.   |                                   |
| 10. CITY OR TOWN OF DEATH<br><b>BALT</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSP.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK OR MOST OF WORKING LIFE)<br><b>Architect Atlantic Division</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE<br><b>MD</b>   |   | 13b. COUNTY<br><b>Balto.</b>  | 13c. CITY OR TOWN<br><b>BALT.</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William N. Lupton</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Cora Ella Lupton</b>  |   |   |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>230-09-7450</b>  |   | 17. INFORMANT ADDRESS<br><b>Mrs. Rachel A. Lupton Randallstown, Md.</b>                         |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiopulmonary arrest resp. failure</b><br><b>5183</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>acute COPD</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>mult. lung infiltrates, pleural effusion, prob. P. embolus</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |   |   |   |   |                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>BPH, ASCVD, 5/PMI, @ adrenal tumor, severe periph. vascular disease</b>   |   |   |   |   |                                   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |                                   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |   |   |   |                                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |                                   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                   |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |   |   |   |   |                                   |
| 22b. SIGNATURE<br><b>E. LIM</b>   |   | DEGREE  |   | 22c. DATE SIGNED<br><b>1-26-82</b>  |                                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>E. LIM</b>  |   | 22e. ADDRESS<br><b>SINAI HOSPITAL OF BALTIMORE</b>  |   |   |                                   |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>  |   | 23b. DATE<br><b>Jan. 30, 1982</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Monticello Memorial</b>                                |                                   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Albemarle Co. Virginia</b>   |   | 23e. DATE REC'D. BY REGISTRAR<br><b>JAN 28 1982</b>   |   |   |                                   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Elaine Funeral Home Reisterstown, Md. 21136</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 28 1982</b>   |   |   |                                   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| FOR<br>STATE<br>REGISTRAR  |  |   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 8 2 0 1 2 2 0<br>REG. NO.  |  |  |  |
|--|--|---|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST <u>Viola</u> MIDDLE <u>J.</u> LAST <u>Lynch</u>   |  |   |  | 2a. DATE OF DEATH<br>MONTH <u>1</u> DAY <u>24</u> YEAR <u>82</u>  |  |  |  | 2b. HOUR<br><u>7:25</u> P.M.   |  |  |  |
| 3. SEX<br><u>F</u>   |  | 4. RACE<br><u>W</u>   |  | 5. DATE OF BIRTH<br>MONTH <u>10</u> DAY <u>29</u> YEAR <u>1900</u>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>81</u> YRS.                                    |  | IF UNDER 1 YEAR<br>MONTHS <u></u> DAYS <u></u>                                       |  | IF UNDER 24 HRS.<br>HOURS <u></u> MIN. <u></u>   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><u>Md.</u>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>Baltimore</u> MD.                         |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><u>Baltimore</u>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>Baltimore City Hospital</u> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>homemaker</u> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>home</u>                                     |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><u>Md.</u>   |  | 13b. COUNTY<br><u>Balto.</u>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><u>325 Conkling St</u>  |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST <u>Steffey</u> MIDDLE <u></u> LAST <u></u>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <u>unk</u> MIDDLE <u></u> LAST <u></u>  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><u>no</u>  |  | 16b. SOCIAL SECURITY NO.<br><u>219163563</u>  |  | 17. INFORMANT<br>ADDRESS<br><u>Mr. Henry Lynch, 325 S. Conkling St</u>  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary collapse</u><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>myocardial infarction</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u> |  |   |  |   |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)   |  |   |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><u>P.M.</u> <u></u> <u></u> <u>19</u>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/27</u> , 19 <u>82</u> , to <u>1/29</u> , 19 <u>82</u> , that (I) (we) lost<br>saw the deceased alive on <u>1/27</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) did/did not see the body after death.                              |  |   |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><u>[Signature]</u>   |  |   |  | DEGREE<br><u></u>   |  |  |  | 22c. DATE SIGNED<br><u>1/24/82</u>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Woyt Stall</u>   |  |   |  | 22e. ADDRESS<br><u>Baltimore City Hospital</u>  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><u>Burial</u>  |  | 23b. DATE<br><u>1/27/82</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Oaklawn Cemetery</u>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Baltimore</u> MD.                   |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>Zannino Funeral Home, 263 S. Conkling St.</u>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><u>JAN 26 1982</u>   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>                                     |  |  |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the Registrar with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  | REG. NO. 8201221  |  |  |  |  |
|---|--|--|--|--|---|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  |  | 2a. DATE OF DEATH   |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>NOAH MacDowell Jr</b>  |  |  |  |  | MONTH DAY YEAR 1 26 82  |  |  |  |  |
| 3 SEX Male  |  |  |  |  | 2b. HOUR 11 <sup>02</sup> A.M.  |  |  |  |  |
| 4. RACE White   |  |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 58  |  |  |  |  |
| 5. DATE OF BIRTH MONTH DAY YEAR 6 21 23   |  |  |  |  | IF UNDER 1 YEAR MONTHS DAYS   |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Hamstead, N.Y.  |  |  |  |  | IF UNDER 24 HRS. HOURS MIN.   |  |  |  |  |
| 7b. CITIZEN OF WHAT COUNTRY? USA  |  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD.  |  |  |  |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH Balto.  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital   |  |  |  |  |   |  |  |  |  |
| 13a. STATE Md.  |  |  |  |  | 13b. COUNTY   |  |  |  |  |
| 13c. CITY OR TOWN Balto.  |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |  |  |  |
| 13e. STREET ADDRESS 820 Harrington Rd.  |  |  |  |  |   |  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST Noah MacDowell  |  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes   |  |  |  |  | 16b. SOCIAL SECURITY NO. 049 18 5042  |  |  |  |  |
| 17. INFORMANT ADDRESS Ruth Langley 820 Harrington Rd.   |  |  |  |  |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Recp-Cardiac arrest</u><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Massive Hemiparesis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Massive Myocardial infarction</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>45m<br>5-7 min<br>45m. |  |  |  |  |   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 16   |  |  |  |  |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  |  |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  |  |  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |   |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  |  |  |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/18, 1982 to 1/26, 1982, that (he) (we) lost saw the deceased alive on 1/26, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |   |  |  |  |  |
| 22b. SIGNATURE <u>[Signature]</u> DEGREE  |  |  |  |  | 22c. DATE SIGNED 1/26/82  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>YEONG DH</u>   |  |  |  |  | 22e. ADDRESS <u>MERCY Hosp</u>  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPEC) CREMATION  |  |  |  |  | 23b. DATE 1/29/82   |  |  |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY WESTVIEW CEM.  |  |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Md.   |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME LEROY O. DYETT 4600 LIBERTY HEIGHTS AVE.  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE FEB 1 1982 <u>Theresa Jan Nardone</u>                          |  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical examiner's certificate must be attached.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 8 2 0 1 2 2 2   |  |
|---|--|---|--|---|--|
| 1- FOR STATE REGISTRAR  |  |   |  | CERTIFICATE OF DEATH  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   |  | 2a. DATE OF DEATH   |  |
| STEPHEN J. MACHLINSKI   |  |   |  | 1-4-82  |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |  |
| Male  |  | Caucasian   |  | 12 2 1916   |  |
| 6. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  |
| Balto.  |  | U.S.A.  |  | 65 YRS.   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |
| Baltimore   |  | Church Home   |  | Baltimore MD.   |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |
| Steel worker  |  | Beth. Steel   |  |   |  |
| 13a. STATE  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  |
| Md.   |  |   |  | Balto   |  |
| 14. FATHER'S NAME<br>(FIRST MIDDLE LAST)  |  | 15. MOTHER'S MAIDEN NAME<br>(FIRST MIDDLE LAST)   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| Zacheusz Machlinski   |  | Magdalene   |  | 13e. STREET ADDRESS   |  |
|   |  |   |  | 100 5 1/2 Street, 21224   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS   |  |
| Yes   |  | WW II   |  | Mrs. Ella Machlinski, same  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CANCER OF THE LUNG WITH METASTASIS</u><br>1629<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-3 19 82, to 1-4 19 82, that (I) (we) saw the deceased alive on 1-4 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  | 22b. SIGNATURE<br><i>A. F. Nour</i>   |  | 22c. DATE SIGNED<br>1-4-82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS  |  |   |  |
| A. F. NOUR, MD.   |  | CHURCH HOSPITAL CORPORATION 100 N. BROADWAY BALTIMORE, MARYLAND 21231                                     |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |
| Burial  |  | 1/8/82  |  | St. Stanislaus  |  |
| 24. FUNERAL DIRECTOR<br>NAME  |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |
| Zannino Funeral Home, 263 S. Conkling St.   |  | JAN 7 1982  |  | <i>James J. Nathan</i>  |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR OR TO FUNERAL DIRECTOR; PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                      |   |   |   |   |  |   |   | REG. NO. 3 2 0 1 2 2 3  |  |
|---|--|----------------------|---|---|---|---|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>John Mack</b>  |  |                      |   |   |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>1 30 1982</b>  |  | 2b. HOUR <b>9:30</b>  |   |   |  |
| 3. SEX <b>Male</b>  |  | 4. RACE <b>Black</b> |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>2 9 1909</b>                |   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <b>72 YRS.</b>   |  | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.                       |   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Va.</b>  |  |                      | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>        |   |   |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>  |  |                      | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Carey St. &amp; Edmondson Ave. (in car)</b> |   |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Shipping Clerk</b>          |   | 12b. KIND OF BUSINESS OR INDUSTRY           |   |  |
| 13a. STATE <b>Md.</b>   |  |                      | 13b. COUNTY   |   | 13c. CITY OR TOWN <b>Balto</b>                                    |   | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |   | 13e. STREET ADDRESS <b>534 N. Carey St.</b> |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>Wendell Mack</b>  |  |                      |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Mack - Brown</b> |   |   |  |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>yes</b>  |  |                      | 16b. SOCIAL SECURITY NO. <b>WW 11 218-03-5268</b>   |   | 17. INFORMANT ADDRESS <b>John H. Mack, Jr. 300 Blackwater Dr.</b> |   |  |   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br><b>4292</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |                      |   |   |   |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |  |                      |   |   |   |   |  |   |   |   |  |
| 19a. DATE OF OPERATION  |  |                      |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                 |   |   |  |   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                      |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19        |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |                      |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)       |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                      |   |   |   |   |  |   |   |   |  |
| ACTUAL SIGNATURE <b>Thomas D. Smith</b>   |  |                      |   | TITLE (SPECIFY) <b>Deputy Chief</b>                               |   |   |  | DATE SIGNED <b>1/30/82</b>  |   |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Thomas D. Smith, M.D.</b>  |  |                      |   | ADDRESS <b>111 Penn St. Balto., Md.</b>                           |   |   |  |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  |                      |   | 23b. DATE <b>2-3-82</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY <b>Crownsville VA.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>Crownsville Md.</b> |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Jas. A. Morton &amp; Sons</b> ADDRESS <b>1701 Laurens St.</b>   |  |                      |   |   |   | 25a. DATE REC'D. BY REGISTRAR <b>FEB 1 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Thomas J. Gault</b>                 |   |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

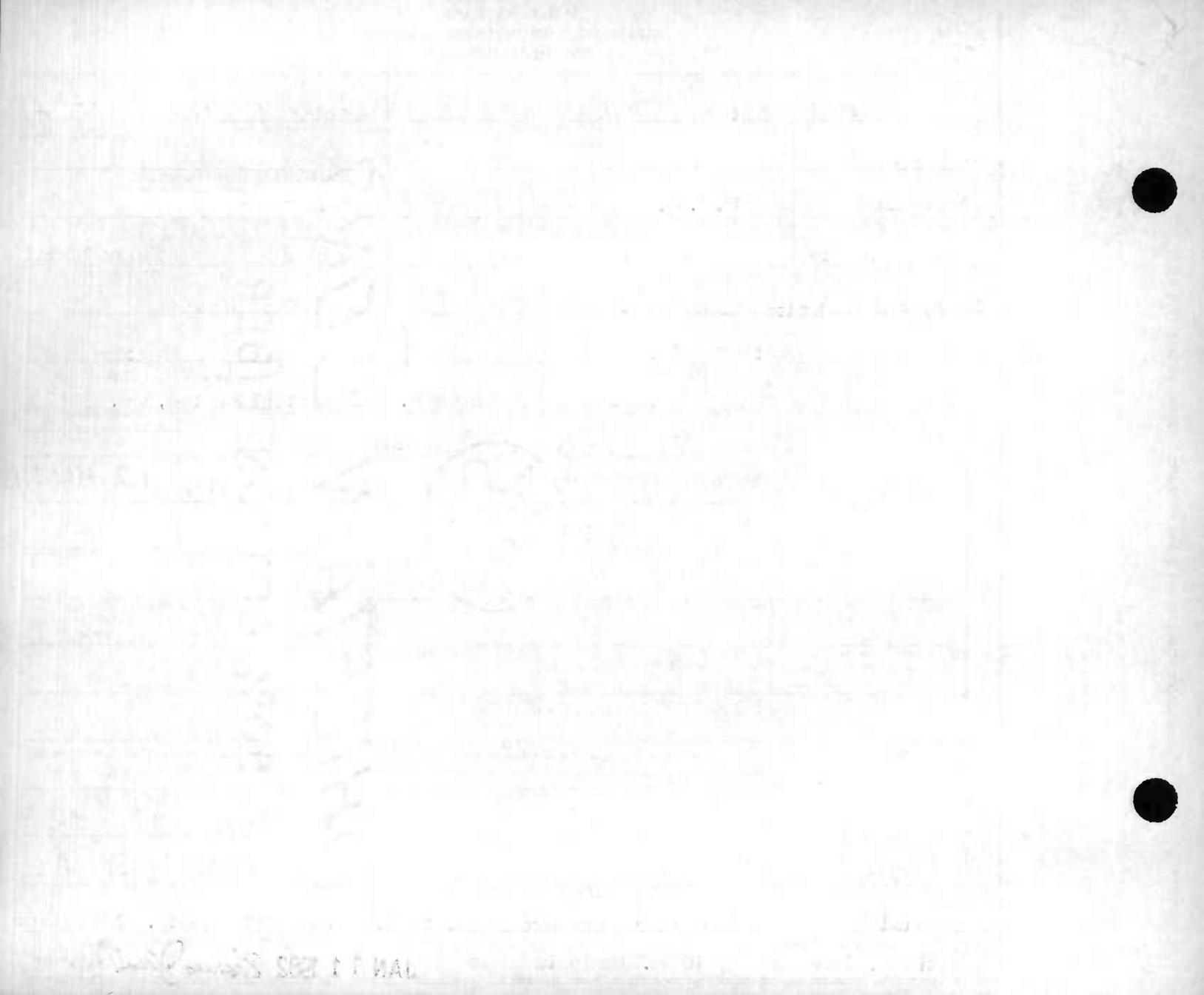
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 2 2 4

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>JOSEPH Anton MACKERT  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>January 9, 1982  |  | 2b. HOUR<br>1:30 AM  |
| 3. SEX<br>Male   | 4. RACE<br>W.C.  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9 4 1916  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>65 YRS.  | 7b. HOUR<br>IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore City  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN "J" OR "K" COLUMN, GIVE STREET ADDRESS)<br>Good Samaritan Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Welder                      | 12b. KIND OF BUSINESS OR INDUSTRY<br>Sheet Metal                               |  |
| 13a. STATE<br>Maryland   | 13b. COUNTY<br>Balto   | 13c. CITY OR TOWN<br>Parkton  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br>17028 Evna Road   | #21120   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Joseph Anton Mackert   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Burton   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes  |  | 16b. SOCIAL SECURITY NO.<br>WW II 213-18-6024   | 17. INFORMANT<br>ADDRESS 17028 Evna Road<br>Carmen D. Mackert, Parkton, Md. 21120               |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) OAT CELL CARCINOMA OF THE<br>1629 LUNG WITH RENAL AND<br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) HEPATIC FAILURE<br>(c) 12 MONTHS |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.   |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from January 6, 1982, to January 9, 1982, that (I) (we) last saw the deceased alive on January 9, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |  |  |
| 22b. SIGNATURE<br>L. Ceballos MD   |  | DEGREE  |   | 22c. DATE SIGNED<br>1/9/82   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>LILIA CEBALLOS  |  | 22e. ADDRESS<br>GOOD SAMARITAN HOSPITAL   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   | 23b. DATE<br>1/12/82   | 23c. NAME OF CEMETERY OR CREMATORY<br>Hereford Baptist Ch.  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Hereford Balto. Maryland         |  |
| 24. FUNERAL DIRECTOR<br>Martin D. Lawson   |  | 10 W. Padonia Road  |   | 25a. DATE REC'D. BY REGISTRAR<br>JAN 11 1982                                   | 25b. REGISTRAR'S SIGNATURE<br>Francis J. Anthony   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 2 2 5

|   |  |  |  |
|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Grace Ethel Mackessy</b><br><i>G. Grace Mackessy</i>   |  | 2a. DATE OF DEATH MONTH <b>1</b> DAY <b>10</b> YEAR <b>82</b> HOUR <b>8:20p</b> M.   |  |
| 3. SEX <b>Female</b><br><i>Female</i>   | 4. RACE <b>White</b>   | 5. DATE OF BIRTH MONTH <b>12</b> DAY <b>10</b> YEAR <b>87</b><br><i>12 10 87</i>   | 6. AGE (IN YEARS LAST BIRTHDAY) <b>94</b><br><i>94</i> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.                |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.   |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Bon Secours Hospital</b> | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>   | 12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>  |
| 13a. STATE <b>Maryland</b>  | 13b. COUNTY <b>Baltimore</b>   | 13c. CITY OR TOWN <b>Catonsville</b>   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |
| 14. FATHER'S NAME FIRST <b>James</b> MIDDLE LAST <b>Martin</b>  | 15. MOTHER'S MAIDEN NAME FIRST <b>Annie</b> MIDDLE <b>I</b> LAST <b>Fowler</b>   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>   | 16b. SOCIAL SECURITY NO. <b>216-32-8165D</b>   | 17. INFORMANT ADDRESS <b>Mary Margaret Woodburn Same as # 13</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line or (a), (b), and (c). PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Stroke</b><br><b>4360</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebral bleeding with hypotension</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Anemia 2° bleeding</b> |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <b>Aseptic gangrene of foot</b>  |  |  |  |
| 19a. DATE OF OPERATION <b>1/10/82</b>   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19 1/10</b>  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/10</b> 19 <b>82</b> to <b>1/10</b> 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>1/10</b> 19 <b>82</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If certified, I did not view the body after death.)             |  |  |  |
| 22b. SIGNATURE <i>[Signature]</i> M.D.  | 22c. DATE SIGNED <b>1/11/82</b>  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JUAN A. BELTRAN</b>   |  |
| 22e. ADDRESS <b>1940 W. BALTIMORE ST. 21223</b>   | 22f. DATE REC'D. BY REGISTRAR <b>JAN 14 1982</b>   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   | 23b. DATE <b>1/14/82</b>   | 23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>   | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>   |
| 24. FUNERAL DIRECTOR <b>Witzke P.A.</b> NAME ADDRESS <b>1630 Edmondson Avenue, Catonsville, Maryland 21228</b>  |  | 25a. DATE REC'D. BY REGISTRAR <b>JAN 14 1982</b> 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>   |  |

MEDICAL CERTIFICATION

BP

2

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 10-10-2001 BY 60322 UCBAW

1. The purpose of this document is to provide a summary of the information received from the source. The information is classified as "Confidential" and is to be handled accordingly. The source has provided information regarding the activities of the group and the individuals involved. The information is being provided for your information and is not to be disseminated outside of your office. The source has provided information regarding the activities of the group and the individuals involved. The information is being provided for your information and is not to be disseminated outside of your office.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |  |  |   |                           |  |  |
|--|--|--|---|--|--|---|---------------------------|--|--|
| 1. FOR STATE REGISTRAR   |  |  | REG. NO.  |  |  |   |                           |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  | 2a. DATE OF DEATH   |  |  | 2b. HOUR  |                           |  |  |
| Grover Macklin   |  |  | January 2, 1982   |  |  | M   |                           |  |  |
| 3. SEX   |  | 4. RACE  |   | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |                           | 7. IF UNDER 1 YEAR   |  |
| Male   |  | Black  |   | 11 30 32   |  | 49  |                           | MONTHS DAYS HOURS MIN  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |                           |  |  |
| VA   |  | USA  |   |  |  | Baltimore City MD   |                           |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |                           | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| Baltimore  |  | 3722 Ellerslie Avenue  |   |  |  |   |                           |  |  |
| 13a. STATE   |  |  | 13b. COUNTY   |  |  | 13c. INSIDE CITY LIMITS?  |                           | 13d. STREET ADDRESS  |  |
| MD   |  |  | Baltimore   |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                           | 3722 Ellerslie Avenue  |  |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME  |  |  |   |                           |  |  |
| Alex Macklin   |  |  | Irene Smith   |  |  |   |                           |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  | 16b. SOCIAL SECURITY NO.  |  |  | 17. INFORMANT ADDRESS   |                           |  |  |
| No   |  |  | 227-38-6257   |  |  | Ruth Harris 3722 Ellerslie Avenue                                   |                           |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Heat Attack</u>  |  |  |   |  |  |   |                           |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 4029 } DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive Heart Failure</u>  |  |  |   |  |  |   |                           |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteria hypertension</u>  |  |  |   |  |  |   |                           |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |   |  |  |   |                           |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |  | 20a. AUTOPSY?   |                           | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |  |   |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                           | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |                           |  |  |
|  |  |  | HOUR A.M. MONTH DAY YEAR  |  |  |   |                           |  |  |
|  |  |  | P.M. 19   |  |  |   |                           |  |  |
| 21d. INJURY OCCURRED   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION  |   |                           |  |  |
| WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  |   |  | CITY OR TOWN COUNTY STATE  |   |                           |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8-15-1</u> 19 <u>81</u> to <u>11-9</u> 19 <u>81</u> that (I) (we) last saw the deceased alive on <u>11-9</u> 19 <u>81</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |   |  |  |   |                           |  |  |
| 22b. SIGNATURE   |  |  | DEGREE  |  |  | 22c. DATE SIGNED  |                           |  |  |
| <u>Aldo Paz</u>  |  |  |   |  |  | 1-4-82  |                           |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  | 22e. ADDRESS  |  |  |   |                           |  |  |
| Aldo Paz-Guevara   |  |  | 1000 Cage St. Balb Md 21202   |  |  |   |                           |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION             |  |  |
| Burial   |  |  | 1/9/82  |  | Church Cem.  |   | CITY OR TOWN COUNTY STATE |  |  |
|  |  |  |   |  |  |   | Bracey VA                 |  |  |
| 24. FUNERAL DIRECTOR   |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR  |   |                           |  |  |
| NAME Wm. C. March F/H 1101 E. North Ave.   |  |  |   |  | JAN 5 1982   |   |                           |  |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 5. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |  | REG. NO. 2 0 1 2 2 7                             |  |                      |  |
|--|--|--|--|--|--|--|--|--|--|--|--|----------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>THEODORE PETER MAGGIO Jr</b>  |  |  |  |  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR <b>1-8-82</b> |  | 2b. HOUR <b>19</b>   |  | 2c. DATE PRONOUNCED DEAD <b>1-8-82</b>           |  | 2d. HOUR <b>1:18</b> |  |
| 3. SEX <b>male</b>   |  | 4. RACE <b>white</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>7/20/16</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS.   |  | IF UNDER 1 YR. MONTHS DAYS HOURS MIN.  |  | 7c. DATE PRONOUNCED DEAD <b>1-8-82</b>           |  | 7d. HOUR <b>19</b>   |  |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Balto. Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>                               |  |  |  |  |  | MD.                  |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1020 E. Baltimore Street</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>R.R. Penn Central</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>R.R.</b>  |  |  |  |                      |  |
| 13a. STATE <b>Md.</b>  |  |  |  | 13b. COUNTY <b>Balto.</b>  |  | 13c. CITY OR TOWN <b>Balto</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <b>1020 E. Baltimore St.</b> |  |                      |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>Theodore P. Maggio</b>   |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Angelina Cicero</b>                     |  |  |  |  |  |                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>No</b>  |  |  |  | 16b. SOCIAL SECURITY NO. <b>216/10/0068</b>  |  | 17. INFORMANT ADDRESS <b>Peter Maggio Rt. 156 Severna Md.</b>                            |  |  |  |  |  |                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a): <b>Arteriosclerotic cardiovascular disease and</b><br><b>4292</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost:<br>(b) <b>seizure disorder</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                      |  |  |  |  |  |  |  |  |  |  |  |                      |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a).   |  |  |  |  |  |  |  |  |  |  |  |                      |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>          |  |  |  |                      |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)            |  |  |  |  |  |                      |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |                      |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |  |  |  |  |  |  |  |  |  |  |                      |  |
| ACTUAL SIGNATURE <b>Margarita A. Korell</b>  |  |  |  | TITLE (SPECIFY) <b>M.D. Assistant</b>  |  |  |  | DATE SIGNED <b>1-8-82</b>  |  |  |  |                      |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>   |  |  |  | ADDRESS <b>111 Penn Street</b>   |  |  |  |  |  |  |  |                      |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  |  |  | 23b. DATE <b>1/11/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>                                  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>Belair Rd. Balto. Md.</b>                      |  |  |  |                      |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Della Noee &amp; sons</b> ADDRESS <b>322 S. HIGH ST.</b>   |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>JAN 11 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>James J. Hatcher</b>   |  |  |  |                      |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 2 2 8

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |   |   |   |  |
|---|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARGARET S MAGRUDER</b>  |   |   | 2a. DATE OF DEATH<br>MONTH <b>1</b> / DAY <b>21</b> / YEAR <b>82</b>                  |   | 2b. HOUR<br><b>10:30</b> A   |
| 3. SEX<br><b>F</b>  | 4. RACE<br><b>W</b>   | 5. DATE OF BIRTH<br>MONTH <b>APRIL</b> DAY <b>17</b> YEAR <b>1891</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>90</b> YRS  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>                                     |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br>COUNTRY <b>MD</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO. CITY</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>N. CHARLES GEN Hosp</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Home Maker</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>At Home</b>                                  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD</b> 13b. COUNTY <b>BALTO</b>   |   |   | 13c. CITY OR TOWN<br><b>BALTO</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>3000 ST. PAUL ST.</b>                                      |
| 14. FATHER'S NAME<br>FIRST <b>William</b> MIDDLE <b>N.</b> LAST <b>Shanklin</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>A</b> MIDDLE <b>OLIVIA</b> LAST <b>Cromwell</b>  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>219-20-6698</b>  |   | 17. INFORMANT<br><b>Family Records</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory failure</b><br>5140<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Pulmonary edema + atelectasis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>GI bleed; Colonic CA</b> |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>sev. days</b><br><b>sev. days</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |   |   |   |   |  |
| 19a. DATE OF OPERATION<br><b>9/9</b>  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>GI bleed; Colonic CA</b>   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |   | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/5/82</b> , 19 <b>82</b> , to <b>1/21</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>1/21</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I (we) (did) (did not) view the body after death.   |   |   |   |   |  |
| 22b. SIGNATURE<br><b>Veneranda G. Barnes</b>  |   | DEGREE<br><b>M.D.</b>   |   | 22c. DATE SIGNED<br><b>1/21/82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>VENERANDA G. BARNES</b>   |   | 22e. ADDRESS<br><b>NORTH CHARLOT GEN. HOSP.</b>   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>CREMATION</b>  |   | 23b. DATE<br><b>1/22/82</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview Memorial</b>                        |   | 23d. LOCATION<br>CITY OR TOWN <b>BALTO</b> COUNTY <b>MD</b>                          |
| 24. FUNERAL DIRECTOR<br>NAME <b>Evans Funeral Chapel</b> ADDRESS <b>8800 Harford Rd</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 27 1982</b>   |   |   |  |

*[Faint, illegible handwritten text on lined paper]*



SEP 18 1912

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |   |  |  |   |  |  |  | 8  | 2   | 0  | 1  | 2   | 2 | 9  |                       |  |
|---|--|--|---|--|--|---|--|--|--|--|---|--|--|---|---|--|-----------------------|--|
| 1 - FOR STATE REGISTRAR   |  |  |   |  |  |   |  |  |  | REG. NO.   |   |  |  |   |   |  |                       |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>James H. Mainhart   |  |  |   |  |  |   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>1 16 82  |   |  |  |   |   |  | 2b. HOUR<br>8:15 P.M. |  |
| 3 SEX<br>Male   |  |  | 4. RACE<br>White  |  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>8 18 07  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS.                 |  |   | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 74 HRS.<br>HOURS MIN.  |   |  |                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Va.  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD. |  |   |  |  |   |   |  |                       |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>340 South Fulton Avenue |  |  |   |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired Machinist |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Bethlehem Steel |   |   |  |                       |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |  |  |   |  |  |   |  |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN<br>Baltimore   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br>340 South Fulton Avenue |                       |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>David Clinton Mainhart   |  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Nora Mae Grimes  |   |  |  |  |  |   |  |  |   |   |  |                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br>No  |  |  | 16b. SOCIAL SECURITY NO.<br>212-03-4344   |  |  | 17. INFORMANT ADDRESS<br>Gladys Mainhart, Same as # 13  |  |  |  |  |   |  |  |   |   |  |                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>Cerebral aneurysm<br>DUE TO, OR AS A CONSEQUENCE OF<br>Cerebral aneurysm<br>DUE TO, OR AS A CONSEQUENCE OF<br>Cerebral aneurysm               |  |  |   |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>4 months<br>1 year                 |   |  |  |   |   |  |                       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |   |  |  |   |  |  |  |  |   |  |  |   |   |  |                       |  |
| 19a. DATE OF OPERATION  |  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>          |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |   |  |                       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |  |   |  |  |   |   |  |                       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |   |  |  |   |   |  |                       |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |   |  |  |   |  |  |  |  |   |  |  |   |   |  |                       |  |
| 22b. SIGNATURE<br>Dr. George Vash   |  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  |  |  | 22c. DATE SIGNED<br>1/18/82  |   |  |  |   |   |  |                       |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. George Vash  |  |  |   |  | 22e. ADDRESS<br>206 S. Gilmore Street, Baltimore, Md. 21223  |   |  |  |  |  |   |  |  |   |   |  |                       |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |  |   |  | 23b. DATE<br>1/20/82   |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Union Cemetery                           |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Lovettsville Virginia |  |  |   |   |  |                       |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Witzke P.A.<br>1630 Edmondson Avenue, Catonsville, Md. 21228  |  |  |   |  |  |   |  |  |  | 25. DATE REC'D BY REGISTRAR<br>JAN 18 1982   |   |  |  |   |   |  |                       |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8 2 0 1 2 3 0  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  | REG. NO.   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>BERNARD GEORGE MAKA   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR<br>JAN 15 82 9:30A M   |  |  |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH<br>11 3 24  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>57 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>VAMC, LOCH RAVEN, BALTIMORE, MD. |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>RETIRED SGT.   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>U.S. ARMY   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>MARYLAND   |  | 13b. CITY OR TOWN<br>CATONSVILLE  |  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13d. STREET ADDRESS<br>1305 DEMBRIGHT ROAD 21228   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>MARTIN MAKA   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>THERESA GROCKI   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(LIVES, NO OR UNKNOWN)<br>YES  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>POST KOREAN 218 18 8459  |  | 17. INFORMANT ADDRESS<br>MARCELLA MAKA 1305 Denbright Rd. 21228  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) UREMIA<br>403) DUE TO, OR AS A CONSEQUENCE OF<br>(b) CHRONIC RENAL FAILURE<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) HYPERTENSION AND DIABETES.<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 weeks<br>2 years<br>10 years |  |   |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan. 6 1982 to Jan 15, 1982, that (I) (we) last saw the deceased alive on Jan. 15 1982, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br>J M Wogan  |  |   |  | DEGREE<br>MD   |  | 22c. DATE SIGNED<br>1/15/81  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>JOHN M. WOGAN   |  |   |  | 22e. ADDRESS<br>3900 LOCH RAVEN BLVD. BALTIMORE, MD 21218  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>CREMATION  |  | 23b. DATE<br>1/18/82  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>WESTVIEW MEMORIAL PARK   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>CATONSVILLE MARYLAND   |  |
| 24. FUNERAL DIRECTOR<br>LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES<br>1630 EDMONDSON AVENUE CATONSVILLE MD. 21228  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 18 1982   |  |  |  |

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*James J. [illegible]*  
JAN 18 1883

JAN 18 1883  
JAMES J. [illegible]  
JAMES J. [illegible]

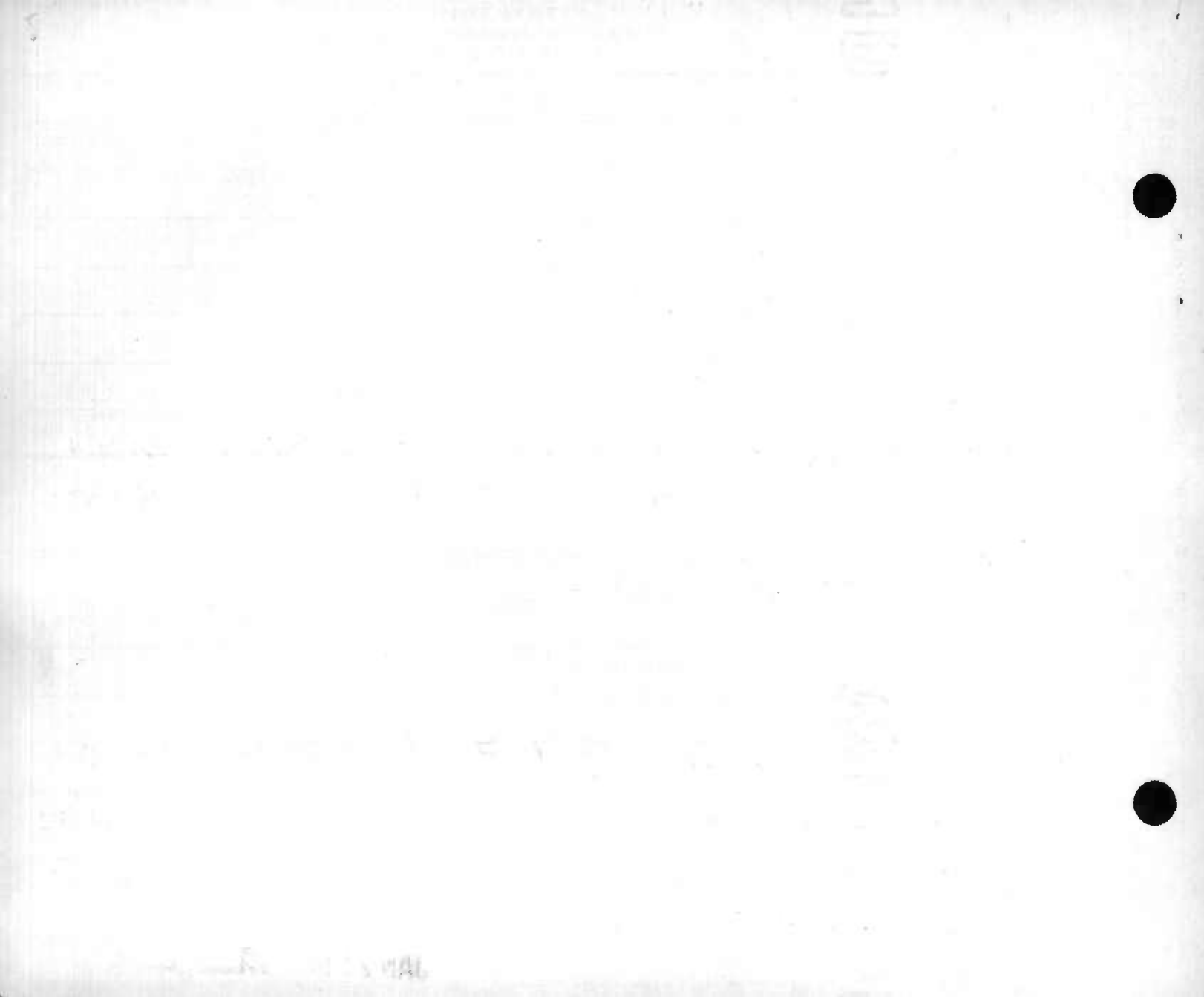


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |                             |  |  |                                    |  |               |  |                                   | 8 2 0 1 2 3 1                                |  |            |  |
|---|--|-----------------------------|--|--|------------------------------------|--|---------------|--|-----------------------------------|--|--|------------|--|
| 1- FOR STATE REGISTRAR  |  |                             | REG. NO.   |  |                                    |  |               |  |                                   |  |  |            |  |
| 1 DECEASED NAME (TYPE OR PRINT)   |  |                             | 2a DATE OF DEATH   |  |                                    | MONTH  |               | DAY  |                                   | YEAR   |  | 2b HOUR    |  |
| Gloria T. Makel   |  |                             | January 16, 1982   |  |                                    |  |               |  |                                   |  |  | M          |  |
| 3 SEX   |  | 4 RACE                      |  | 5 DATE OF BIRTH  |                                    | 6 AGE (IN YEARS LAST BIRTHDAY)   |               | IF UNDER 1 YEAR  |                                   | IF UNDER 24 HRS                              |  |            |  |
| Female  |  | Black                       |  | 10 <sup>TH</sup> 25 30 <sup>TH</sup>   |                                    | 51   |               | MONTHS   |                                   | DAYS   |  | HOURS MIN. |  |
| 7b BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7c CITIZEN OF WHAT COUNTRY? |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9 BALTIMORE CITY OR COUNTY OF DEATH  |               |  |                                   |  |  |            |  |
| MD  |  | USA                         |  |  |                                    | Baltimore City MD.   |               |  |                                   |  |  |            |  |
| 10 CITY OR TOWN OF DEATH  |  |                             | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                                    | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |               |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |            |  |
| Baltimore   |  |                             | Lutheran Hospital  |  |                                    |  |               |  |                                   |  |  |            |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |                             | 13b CITY OR TOWN   |  |                                    | 13c INSIDE CITY LIMITS?  |               |  | 13d STREET ADDRESS                |  |  |            |  |
| MD  |  |                             | Baltimore  |  |                                    | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |               |  | 602 Grantley St.                  |  |  |            |  |
| 14 FATHER'S NAME  |  |                             | 15. MOTHER'S MAIDEN NAME   |  |                                    |  |               |  |                                   |  |  |            |  |
| John Brown  |  |                             | Beatrice Holt  |  |                                    |  |               |  |                                   |  |  |            |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |                             | 16b SOCIAL SECURITY NO.  |  |                                    | 17 INFORMANT ADDRESS   |               |  |                                   |  |  |            |  |
| No  |  |                             | 212-26-5986  |  |                                    | Beatrice Brown 602 Grantley St.  |               |  |                                   |  |  |            |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4360 CEREBRAL VASCULAR ACCIDENT   |  |                             |  |  |                                    |  |               |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |            |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |                             |  |  |                                    |  |               |  |                                   | 30 MIN.                                      |  |            |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) HYPERTENSION   |  |                             |  |  |                                    |  |               |  |                                   | 10 YRS.                                      |  |            |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |                             |  |  |                                    |  |               |  |                                   |  |  |            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) HYPERGLYCEMIA   |  |                             |  |  |                                    |  |               |  |                                   |  |  |            |  |
| 19a DATE OF OPERATION   |  |                             | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |                                    | 20a AUTOPSY?   |               | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                                   |  |  |            |  |
|   |  |                             |  |  |                                    | YES <input type="checkbox"/> NO <input type="checkbox"/>   |               | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                                   |  |  |            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                             | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |               |  |                                   |  |  |            |  |
|   |  |                             | P.M. 19  |  |                                    |  |               |  |                                   |  |  |            |  |
| 21d INJURY OCCURRED   |  |                             | 21a. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  |                                    | 21i. LOCATION  |               |  | CITY OR TOWN COUNTY STATE         |  |  |            |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |                             |  |  |                                    | STREET   |               |  |                                   |  |  |            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 17 SEPT '81 to 8 JAN 82, 19 82, that (I) (we) last saw the deceased alive on 8 JAN 19 82, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                             |  |  |                                    |  |               |  |                                   |  |  |            |  |
| 22b. SIGNATURE  |  |                             | DEGREE   |  |                                    | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |               |  | 22c. DATE SIGNED                  |  |  |            |  |
| JOHN H. HOLMES III  |  |                             | M.D.   |  |                                    |  |               |  | 19 JAN '82                        |  |  |            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |                             | 22e. ADDRESS   |  |                                    |  |               |  |                                   |  |  |            |  |
| JOHN H. HOLMES III M.D.   |  |                             | 4200 EDMONDSON AVE. BALTO. MD. 212-29  |  |                                    |  |               |  |                                   |  |  |            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |                             | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY |  | 23d. LOCATION |  | CITY OR TOWN COUNTY STATE         |  |  |            |  |
| Burial  |  |                             | 1/21/82  |  | Westview Mem. Pk.                  |  | Baltimore     |  | Co. MD                            |  |  |            |  |
| 24 FUNERAL DIRECTOR   |  |                             | 25a. DATE REC'D. BY REGISTRAR  |  |                                    | 25b. REGISTRAR'S SIGNATURE   |               |  |                                   |  |  |            |  |
| Wm. C. March F/H 1101 E. North Ave.   |  |                             | JAN 21 1982  |  |                                    | [Signature]  |               |  |                                   |  |  |            |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-1234.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

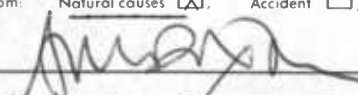

8 2 0 1 2 3 2

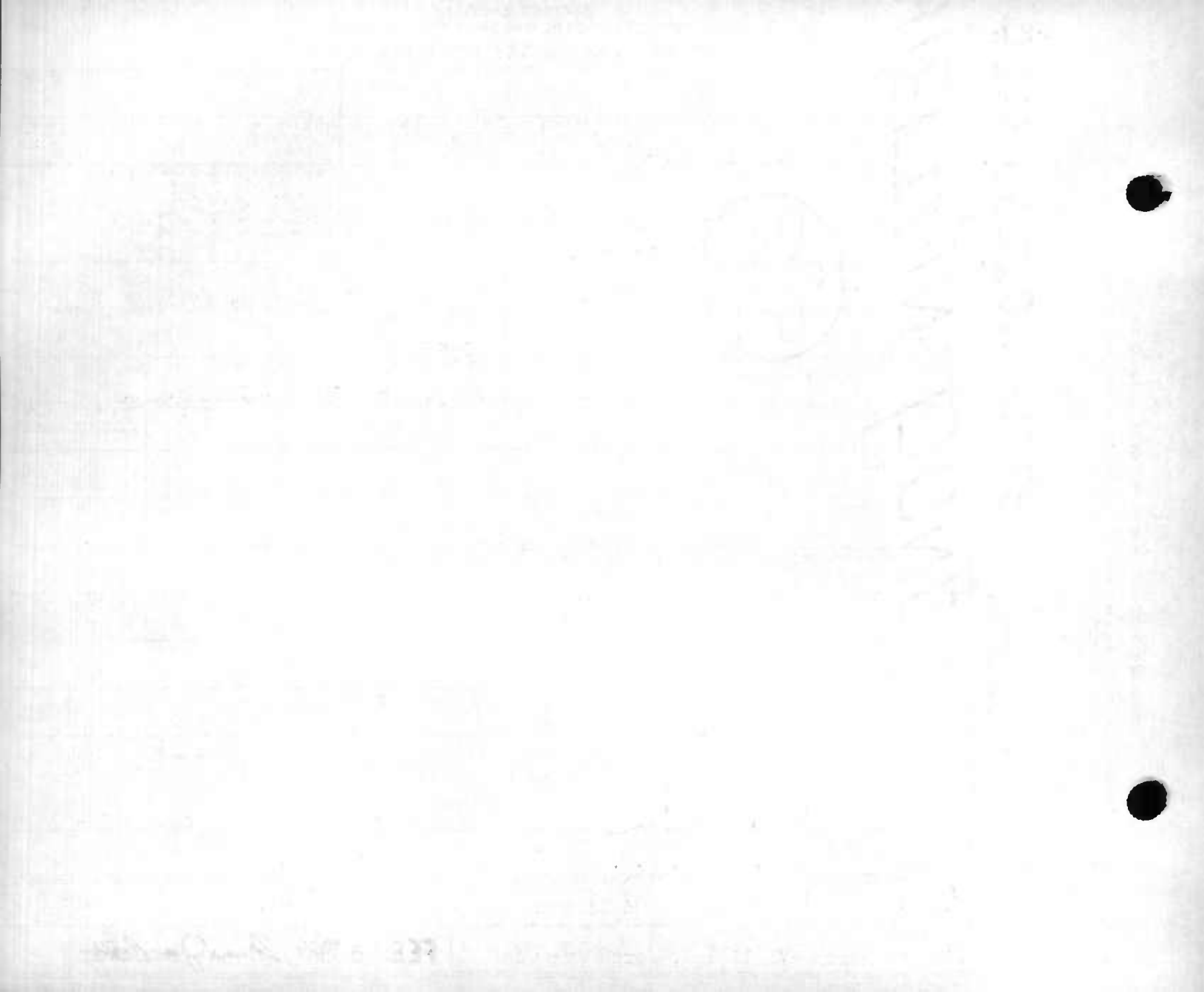
REG. NO.

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>HANNAH E. MALMAN</b>   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>1 4 82</b>                                    |   | 2b. HOUR<br><b>6 A</b>   |
| 3. SEX<br><b>FEMALE</b>  | 4. RACE<br><b>WHITE</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 17 04</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS.                                    |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>CITY</b>                                  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAL HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b> | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b>                       |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b>  |  |   | 13b. COUNTY<br><b>BALT</b>   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                                     | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ABRAHAM JONTIFF</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE<br><b>DORA EZERSKY</b>                      |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>215-34-0745</b>  | 17. INFORMANT<br><b>MRS. ESTA LESSER</b><br><b>118 SWANHILL CT. BALTO., MD 21208</b> |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>CVA</b><br><b>4360</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Arteriosclerosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/3</b> 19 <b>82</b> , to <b>1/4</b> 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>1/3</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.                  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Harvey Rosen</b>  |  | DEGREE  |  | 22c. DATE SIGNED<br><b>1/4/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Harvey Rosen</b>   |  | 22e. ADDRESS<br><b>SINAL HOSP OF BALTIMORE</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   | 23b. DATE<br><b>JAN. 6, 1982</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BETH TFILOH</b>  |  | 23d. LOCATION<br><b>BALTIMORE</b> COUNTY <b>MARYLAND</b>                  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b><br>ADDRESS<br><b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>  |  |   | 25a. DATE REC'D BY REGISTRAR<br><b>JAN 7 1982</b>                                    |   |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                  |  |   |  |   |  |   |  | REG. NO. 2 0 1 2 3 3   |  |   |  |
|--|--|------------------|--|---|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>WALTER MALOY  |  |                  |  |   |  |   |  |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br>1 28 1982 |  | 2b. HOUR<br>M<br>4:38<br>a M  |  |
| 3. SEX<br>male   |  | 4. RACE<br>negro |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>6 15 1898   |  | 6. AGE (IN YEARS<br>LAST BIRTHDAY)<br>83 YRS.                                 |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>1 28 1982  |  | 2d. HOUR<br>a M   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md  |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>706 Glenwood Ave. |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br>Md   |  |                  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br>706 Glenwood Avenue   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Unknown  |  |                  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Unknown                      |  |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>Yes   |  |                  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>220-09-5244  |  | 17. INFORMANT<br>ADDRESS<br>Martha Goode 706 Glenwood Avenue                  |  |   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Congestive heart failure</u><br>4280<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                 |  |                  |  |   |  |   |  |   |  |  |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                  |  |   |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                  |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |   |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |   |  |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                  |  |   |  |   |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE<br>  |  |                  |  | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER  |  |   |  | DATE SIGNED 1-28-82   |  |  |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Ann M. Dixon, M.D.  |  |                  |  | ADDRESS<br>111 Penn St.   |  |   |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |                  |  | 23b. DATE<br>2/3/82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Md Veteran Cemetery                     |  |   |  | 23d. LOCATION<br>Crownsville COUNTY Md STATE   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>William C. March F/H 1101 E. North Avenue  |  |                  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 3 1982                                   |  |   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br> |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |  |  | 8 2 0 1 2 3 4  |     |                                   |  |
|--|--|--|--|--|--|---|--|--|--|--|-----|-----------------------------------|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO.   |  |  |  |   |  |  |  |  |     |                                   |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST  |  | MIDDLE   |  | LAST  |  | 2a. DATE OF DEATH  |  | MONTH  | DAY | YEAR                              | 2b. HOUR                                     |
| JOSEPH P. MANZO  |  |  |  |  |  |   |  | 1 15 82  |  |  |     |                                   | 5:20 PM                                      |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | 7. IF UNDER 1 YEAR   |  | 8. IF UNDER 24 HRS   |     |                                   |  |
| MALE   |  | WHITE  |  | March 19, 1900   |  | 81  |  | MONTHS   |  | DAYS   |     | HOURS MIN.                        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |  |     |                                   |  |
| Pennsylvania   |  | U.S.A.   |  |  |  | baltimore City MD.  |  |  |  |  |     |                                   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  |   |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |     | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| Baltimore  |  | Sinai Hospital   |  |  |  |   |  |  |  | Crane Operator   |     | B.G. & E.                         |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS  |  |  |     |                                   |  |
| Maryland   |  |  |  | Baltimore  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 2827 Harview Ave.  |  |  |     |                                   |  |
| 14. FATHER'S NAME  |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |   |  |  |  |  |     |                                   |  |
| Daniel   |  |  |  | Anna   |  |   |  | DiSara   |  |  |     |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES)   |  |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | ADDRESS  |  |  |     |                                   |  |
| NO   |  |  |  | 215-10-1174  |  | Virginia Guariglia  |  | 2827 Harview Ave.  |  |  |     |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:  |  |  |  |  |  |   |  |  |  |  |     |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) 1890 MASSIVE CVA   |  |  |  |  |  |   |  |  |  |  |     |                                   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC DISEASE  |  |  |  |  |  |   |  |  |  |  |     |                                   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.   |  |  |  |  |  |   |  |  |  |  |     |                                   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) HYPERNEPHROMA   |  |  |  |  |  |   |  |  |  |  |     |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.  |  |  |  |  |  |   |  |  |  |  |     |                                   |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |     |                                   |  |
|  |  |  |  |  |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |     |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |     |                                   |  |
|  |  |  |  | HOUR A.M. MONTH DAY YEAR   |  |   |  |  |  |  |     |                                   |  |
|  |  |  |  | P.M. 19  |  |   |  |  |  |  |     |                                   |  |
| 21d. INJURY OCCURRED   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |   |  | 21f. LOCATION  |  |  |     |                                   |  |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  |  |  |  |   |  | STREET CITY OR TOWN COUNTY STATE   |  |  |     |                                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost   |  |  |  |  |  |   |  |  |  |  |     |                                   |  |
| saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |  |  |  |     |                                   |  |
| 22b. SIGNATURE   |  |  |  |  |  |   |  | DEGREE   |  | 22c. DATE SIGNED   |     |                                   |  |
| Eduardo Anhalt   |  |  |  |  |  |   |  | MD   |  |  |     |                                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  |  |  |   |  | 22e. ADDRESS   |  |  |     |                                   |  |
| EDUARDO ANHALT   |  |  |  |  |  |   |  | Sinai Hospital   |  |  |     |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY                                  |  |  |  | 23d. LOCATION  |     |                                   |  |
| Burial   |  |  |  | Jan. 19, 1982  |  | Moreland Mem. Park  |  |  |  | CITY OR TOWN COUNTY STATE                                      |     |                                   |  |
|  |  |  |  |  |  |   |  |  |  | Baltimore Maryland   |     |                                   |  |
| 24. FUNERAL DIRECTOR   |  |  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE                                     |     |                                   |  |
| Leonard J. Ruck, Inc. Baltimore, Maryland  |  |  |  |  |  |   |  | JAN 19 1982  |  | Francis Jan Thornton   |     |                                   |  |



1985 JAN 18

X

ADVICE OF RIGHTS

Handwritten notes on the right margin, including "1/18/85" and "1/18/85".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 2 0 1 2 3 5   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Joseph Maranto   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>Jan. 15, 1982  |  | 2b. HOUR<br>P. M.<br>6:30 P.   |  |
| 3. SEX<br>Male  |  | 4. RACE<br>Caucasian  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>April 2, 1893   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>88<br>YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Italy  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3518 Elmora Ave. 21213 |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Barber  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Self-Emp.   |  |
| 13a. STATE<br>Maryland  |  |   |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Baltimore   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Francis Maranto   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Virginia Messina   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No  |  |   |  | 16b. SOCIAL SECURITY NO.<br>219-32-0434   |  | 17. INFORMANT<br>ADDRESS<br>Sadie Maranto Same as 13c  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u><br>4360<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Cerebral vessel disease</u><br>3-4 yrs<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>24 hours |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br>/   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>/   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br>/   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>/   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>/  |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>Dec 27, 1946</u> to <u>JAN 14, 1982</u> , that (I) (we) last saw the deceased alive on <u>JAN 14, 1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.                         |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>[Signature]</u><br>DEGREE<br>M.D.<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  |   |  | 22c. DATE SIGNED<br>1/18/82   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Edwin Berstock   |  |   |  | 22e. ADDRESS<br>302 E. 33rd St.   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>1/19/82  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Redeemer   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Md.   |  |
| 24. FUNERAL DIRECTOR<br>Schimunek Funeral Home, Inc.<br>3331 Brehms La.-Balto., Md. 21213   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 19 1982  |  |  |  |
|   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |  |  |  |

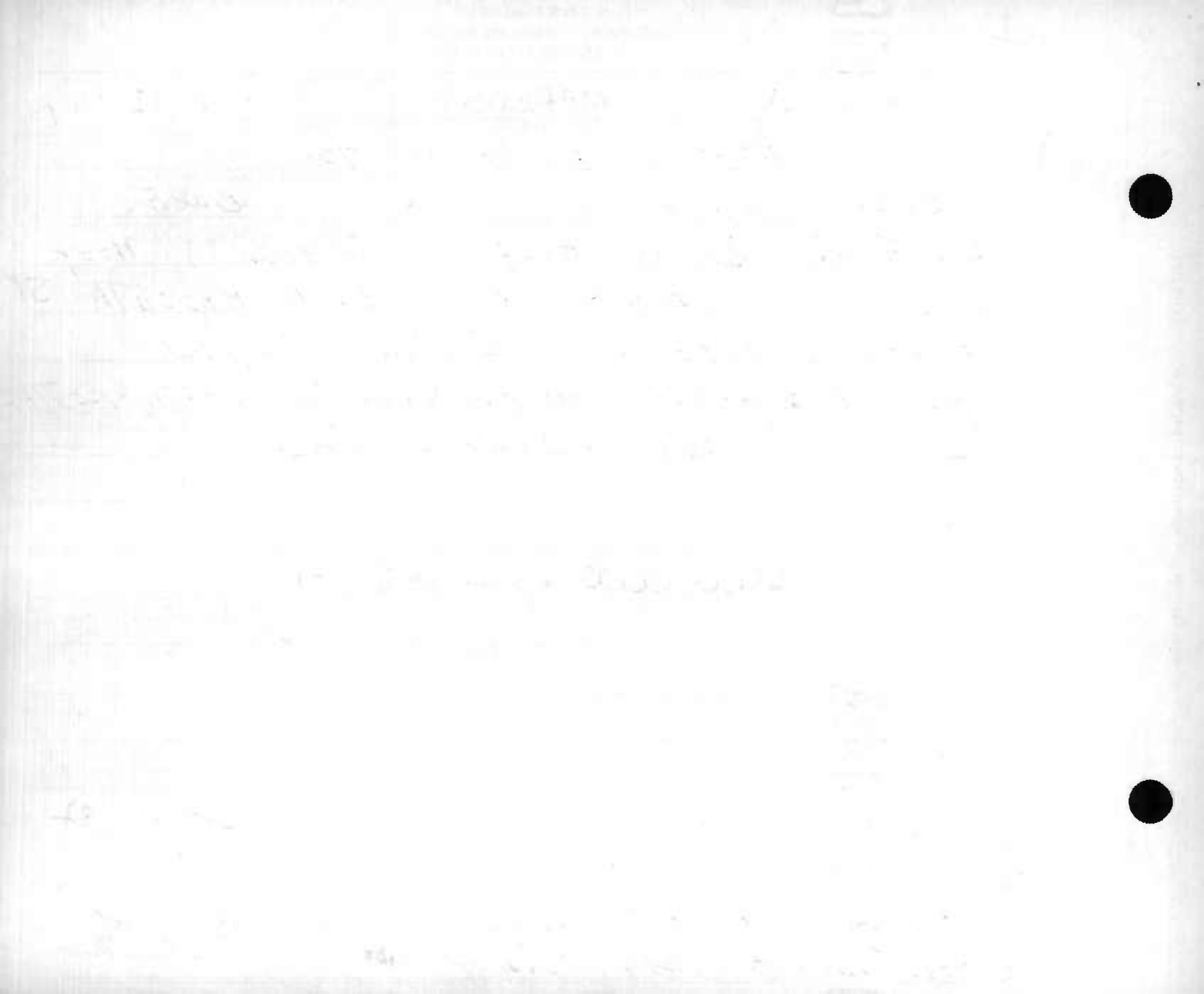


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8 2 0 1 2 3 6  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>NATHANIEL MARCUS   |  |   |  | 2a. DATE OF DEATH<br>1 1 82  |  |  |  |
| 3 SEX<br>M   |  |   |  | 7b. HOUR<br>1:30 PM  |  |  |  |
| 4 RACE<br>NEGRO  |  | 5. DATE OF BIRTH<br>3 18 09   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>72   |  | 7b. HOUR<br>1:30 PM  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>S.C.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>   |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Balt.   |  |
| 10 CITY OR TOWN OF DEATH<br>Balt. Md   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Sinai Hosp |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Orderly   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Hosp.   |  |
| 13a. STATE<br>Md   |  | 13b. COUNTY<br>Balt.  |  | 13c. CITY OR TOWN<br>Balt.   |  | 13d. STREET ADDRESS<br>36 N. Kossuth St  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>HENRY MARCUS   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Julia Dykes  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>YES   |  | 16b. SOCIAL SECURITY NO.<br>91442-44 216-09-7898A  |  |
| 17 INFORMANT<br>Ber. Mother  |  | 17 ADDRESS<br>36 N. Kossuth St  |  | 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 1850<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>Septicemia due to UTI   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |  |  |
| 22a. SIGNATURE<br>Jose R Alvarez   |  | DEGREE<br>MD  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  | 22c. DATE SIGNED<br>1 1 82   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>JOSE R ALVAREZ MD   |  | 22e. ADDRESS<br>Sinai Hospital  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>1/6/82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Md. Veterans Cemetery  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Chesapeake, Md   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Locke Funeral Home   |  | ADDRESS<br>1304 N. Central Ave  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 4 1982  |  | 25b. REGISTRAR'S SIGNATURE<br>Rome Jan North   |  |



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| FOR STATE REGISTRAR  |  |   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO. 8 2 0 1 2 3 7  |  |  |  |
|--|--|---|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>James P. Margaritis  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>January 22, 1982  |  |   |  | 2b. HOUR<br>10 PM   |  |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>June 29, 1921  |  | 6. AGE (IN YEARS (LAST BIRTHDAY))<br>60 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pa.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Balto. City Md. MD.                                     |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Balto.  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>527 Yale Ave. |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Salesman                       |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| 13a. STATE<br>Md.  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>527 Yale Ave.                                      |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Peter Margaritis  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Anastasia Chiadis   |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>072-12-3705   |  | 17. INFORMANT ADDRESS<br>Lavinia L. Margaritis 527 Yale Ave   |  |   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4292<br>DUE TO, OR AS A CONSEQUENCE OF (b) Yuba City<br>DUE TO, OR AS A CONSEQUENCE OF (c) ACCIDENT<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 hr                      |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 76 to 19 82, that (I) (we) lost saw the deceased alive on 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>GAYMOND B. BAKER   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                   |  |   |  | 22c. DATE SIGNED<br>1-26-82   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>GAYMOND B. BAKER  |  |   |  | 22e. ADDRESS<br>ST 100  |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>1-25-82  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>BREECH CEMETERY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>BALTO  |  |   |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>Weber Funeral Home  |  |   |  | ADDRESS<br>5311 Edmondson Ave.  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 26 1982                              |  | 25b. REGISTRAR'S SIGNATURE<br>J. N. Nathan   |  |



Handwritten text, possibly a date or reference number, including "1942" and "MS".

Handwritten text, possibly a signature or date, including "24/12" and "1942".



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| STATE OF MARYLAND  |  |  |  |  |  |   |  |   |  |
|--|--|--|--|--|--|---|--|---|--|
| DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |  |  |   |  |   |  |
| CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |   |  |
| 1 - FOR STATE REGISTRAR  |  | REG. NO. 8 2 0 1 2 3 8   |  |  |  |   |  |   |  |
| 1 DECEASED NAME (TYPE OR PRINT)  |  | FIRST  |  | MIDDLE   |  | LAST  |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |
| Sophia   |  | H.   |  | Margolin   |  |   |  | 1 4 82  |  |
| 3 SEX  |  | 4 RACE   |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6 AGE (IN YEARS LAST BIRTHDAY)  |  | 2b. HOUR  |  |
| FEMALE   |  | Cauc   |  | 2 09 01  |  | 80  |  | 12 Noon   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH   |  |   |  |
| MARYLAND   |  | USA  |  |  |  | XXXXXXXXXX BALTO. CITY MD   |  |   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                     |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| Baltimore  |  | Sinai Hospital   |  |  |  | Housewife   |  | AT HOME   |  |
| 13a. STATE   |  | 13b. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS   |  | 12b. APT. #   |  |
| Md   |  | BALTO.   |  |  |  | 5947 Western Park Dr  |  | #21209  |  |
| 14 FATHER'S NAME   |  |  |  | 15 MOTHER'S MAIDEN NAME  |  |   |  |   |  |
| HESEL  |  |  |  | JENNIE   |  |   |  | DAVIS   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  |   |  |   |  |
| NO   |  | 216-03-6679D   |  | MRS. ESTHER RUTH KNOPFMACHER   |  |   |  |   |  |
|  |  |  |  | 929 GABEL CT., SILVER SPRING, MD 20901   |  |   |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 1. DEATH WAS CAUSED BY:   |  |  |  |  |  |   |  | 18 months   |  |
| IMMEDIATE CAUSE (a) <u>Widespread lymphoma</u>   |  |  |  |  |  |   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |   |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |  |  |  |  |  |   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |   |  |   |  |
| <u>Septicemia</u>  |  |  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |  |   |  |
|  |  | P.M. 19  |  |  |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21i. LOCATION STREET   |  | CITY OR TOWN  |  | COUNTY STATE  |  |
|  |  |  |  |  |  |   |  |   |  |
| 22a. I certify that (this hospital) attended the deceased from 12/4 19 81 to Jan 4 19 82, that (I) (we) last saw the deceased alive on Jan 4 19 81 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death. |  |  |  |  |  |   |  |   |  |
| 22b. SIGNATURE   |  |  |  | DEGREE   |  |   |  | 22c. DATE SIGNED  |  |
| Wendy Kellner  |  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |  |   |  | 1/4/82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | 22e. ADDRESS   |  |   |  |   |  |
| Wendy Kellner  |  |  |  | Sinai Hospital   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN  |  | COUNTY STATE  |  |
| BURIAL   |  | JAN. 6, 1982   |  | HEBREW FRIENDSHIP  |  | BALTIMORE   |  | MARYLAND  |  |
| 24 FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC.  |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |
| 6010 REISTERSTOWN RD. BALTO., MD 21215   |  |  |  | JAN 7 1982   |  | James J. K. Kellner   |  |   |  |

SECTION 10-10



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 2 3 9

REG. NO.

|   |  |   |   |   |                                     |   |  |  |  |                                |  |
|---|--|---|---|---|-------------------------------------|---|--|--|--|--------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>HELEN MARY MARSH</b> |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1-20-82</b> |   | 2b. HOUR<br>G <b>6</b> P <b>1</b> M |   |  |  |  |                                |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>CAUCASION</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10-16-96</b>   |                                     | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS                           |  | IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>MD</b>                           |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                     | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |  |  |                                |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BON SECOUR HOSPITAL</b> |   |   |                                     | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>-</b>            |  |                                |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Rockdale</b>  |                                     | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>3521 Abbie Place</b>           |  |                                |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Henry Waterman</b>                     |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anna Thune</b>  |                                     |   |  |  |  |                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>219-10-289</b>   |   | 17. INFORMANT<br><b>Mr. James E. Marsh</b>  |                                     |   |  | ADDRESS<br><b>3216 Gorham Court, Baltimore, MD 21227</b> |  |                                |  |

|  |  |  |  |
|--|--|--|--|
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO - RESPIRATORY ARREST</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                |  |
| 4280<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |  | (b) <b>DUE TO HYPOTENSION DUE TO CARDIOGENIC SHOCK</b>         |  |
|  |  | (c) <b>DUE TO RENAL INSUFFICIENCY CONGESTIVE HEART FAILURE</b> |  |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  
**HYPERPARATHYROIDISM, UNCONTROLLED DIABETES; CVA (2) HEMIPARESIS**

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 19a. DATE OF OPERATION<br><b>1/20/82</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>UNCONTROLLED DIABETES</b>      |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>1/20 82</b>                     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>UNCONTROLLED DIABETES</b> |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>HOME</b> |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>Baltimore City MD</b>                                 |  |   |  |
| 22a. I certify that this hospital attended the deceased from <b>1/20 82</b> to <b>1/20 82</b> , that I saw the deceased alive on <b>1/20 82</b> , and that in my opinion death occurred on the date and hour and from the causes stated above (we) (we) (we) did not view the body after death. |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Howard B. Chen, M.D.</b>   |  |   |  | DEGREE<br><b>M.D.</b>   |  | 22c. DATE SIGNED<br><b>1/20/82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HOWARD B. CHEN, M.D.</b>  |  |   |  | 22e. ADDRESS<br><b>BON SECOURS HOSPITAL</b>   |  |   |  |

|   |  |                             |  |   |  |  |  |
|---|--|-----------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>               |  | 23b. DATE<br><b>1/23/82</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge Cemetery</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Pikesville Baltimore MD</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Loring Byers Funeral Directors, Inc.</b> |  |                             |  | 25a. DATE RECD. BY REGISTRAR<br><b>JAN 25 1982</b>                |  |  |  |
| 8728 Liberty Road Randallstown, Maryland 21133                              |  |                             |  | Signature<br><b>Charles J. [Signature]</b>                        |  |  |  |

10-10-10



Page 30

Handwritten signature and date at the bottom left corner.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR A15 ME (1))  
15M 2/80

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                      |  |   |  |   |  |   |  | REG. NO. 2 0 1 2 4 0  |  |
|--|--|----------------------|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Carroll Marshall</b>  |  |                      |  |   |  |   |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>1</b> DAY <b>22</b> YEAR <b>19 82</b>  |  | 2b. HOUR <b>M</b>   |  |
| 3. SEX <b>Male</b>   |  | 4. RACE <b>Black</b> |  | 5. DATE OF BIRTH<br>MONTH <b>9</b> DAY <b>13</b> YEAR <b>30</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>51</b> YRS.  |  | IF UNDER 1 YR. MONTHS <b></b> DAYS <b></b>  |  | IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>  |  |                      |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City,</b> MD.                     |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |  |                      |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University Hospital</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE <b>Maryland</b>   |  |                      |  | 13b. COUNTY <b></b>   |  | 13c. CITY OR TOWN <b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS <b>1405 Washington Blvd.</b>                                    |  |
| 14. FATHER'S NAME<br>FIRST <b></b> MIDDLE <b></b> LAST <b></b>   |  |                      |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b></b> MIDDLE <b></b> LAST <b>Burdell Marshall</b> |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>Yes</b>   |  |                      |  | 16b. SOCIAL SECURITY NO. <b>WW 11</b>   |  | 17. INFORMANT <b>Juanita Marshall-same as above</b> ADDRESS <b></b>                   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b><br>4292<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) <b></b><br>(c) <b></b><br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF  |  |                      |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                      |  |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                      |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)         |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET <b></b> CITY OR TOWN <b></b> COUNTY <b></b> STATE <b></b>     |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                      |  |   |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE <b>Margarita A. Korell</b>  |  |                      |  | TITLE (SPECIFY) <b>Assistant</b> MEDICAL EXAMINER   |  |   |  | DATE SIGNED <b>1-22-82</b>  |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>   |  |                      |  | ADDRESS <b>111 Penn Street</b>  |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>  |  |                      |  | 23b. DATE <b>1-26-82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Md. Vet. Cem.</b>                               |  | 23d. LOCATION<br>CITY OR TOWN <b>Crownsville</b> COUNTY <b></b> STATE <b>Md.</b>  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>CHAS. A. RICE FSPA</b> ADDRESS <b>1300 Eutaw Pl.</b>   |  |                      |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>FEB 5 1982</b>                                       |  | 25b. REGISTRAR'S SIGNATURE <b>James J. Marshall</b>   |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. It must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |   |   |  | 8 2 0 1 2 4 1   |  |
|--|---|---|--|---|--|
| 1 - FOR STATE REGISTRAR  |   |   |  | REG. NO.  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>JOHN N. MARSHALL</b>   |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>JANUARY 24, 1982</b>                    |   | 2b. HOUR<br><b>1:45a</b><br>M  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>Black</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 22 23<sup>R</sup></b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>58</b><br>YRS.                           |   | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VA</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b><br>MD.           |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b> |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br><b>MD</b>  |   | 13b. COUNTY   | 13c. CITY OR TOWN<br><b>Baltimore</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             | 13e. STREET ADDRESS<br><b>620 Wyanoke Ave.</b>   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Raymond Marshall</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Marjorie Madison</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>224-26-7926</b>  | 17. INFORMANT ADDRESS<br><b>Mildred Marshall 620 Wyanoke Ave.</b>              |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiopulmonary arrest</b><br>1629 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hypoxia</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Lung cancer</b>              |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>minutes</b><br><b>hours</b><br><b>weeks</b>                             |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |   |   |  |   |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/18</b> , 19 <b>82</b> , to <b>1/24</b> , 19 <b>82</b> , that (we) last saw the deceased alive on <b>1/24</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |   |   |  |   |  |
| 22b. SIGNATURE<br><b>Steven P. Schuman</b>   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>1/24/82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Steven P. Schuman</b>  |   | 22e. ADDRESS<br><b>601 W Broadway Bldg 21205</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   | 23b. DATE<br><b>1/30/82</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Highrock Cem.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Farmville VA</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H</b>  |   | ADDRESS<br><b>1101 E. North Ave.</b>  |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>JAN 27 1982</b> <i>Thomas J. [Signature]</i> |  |



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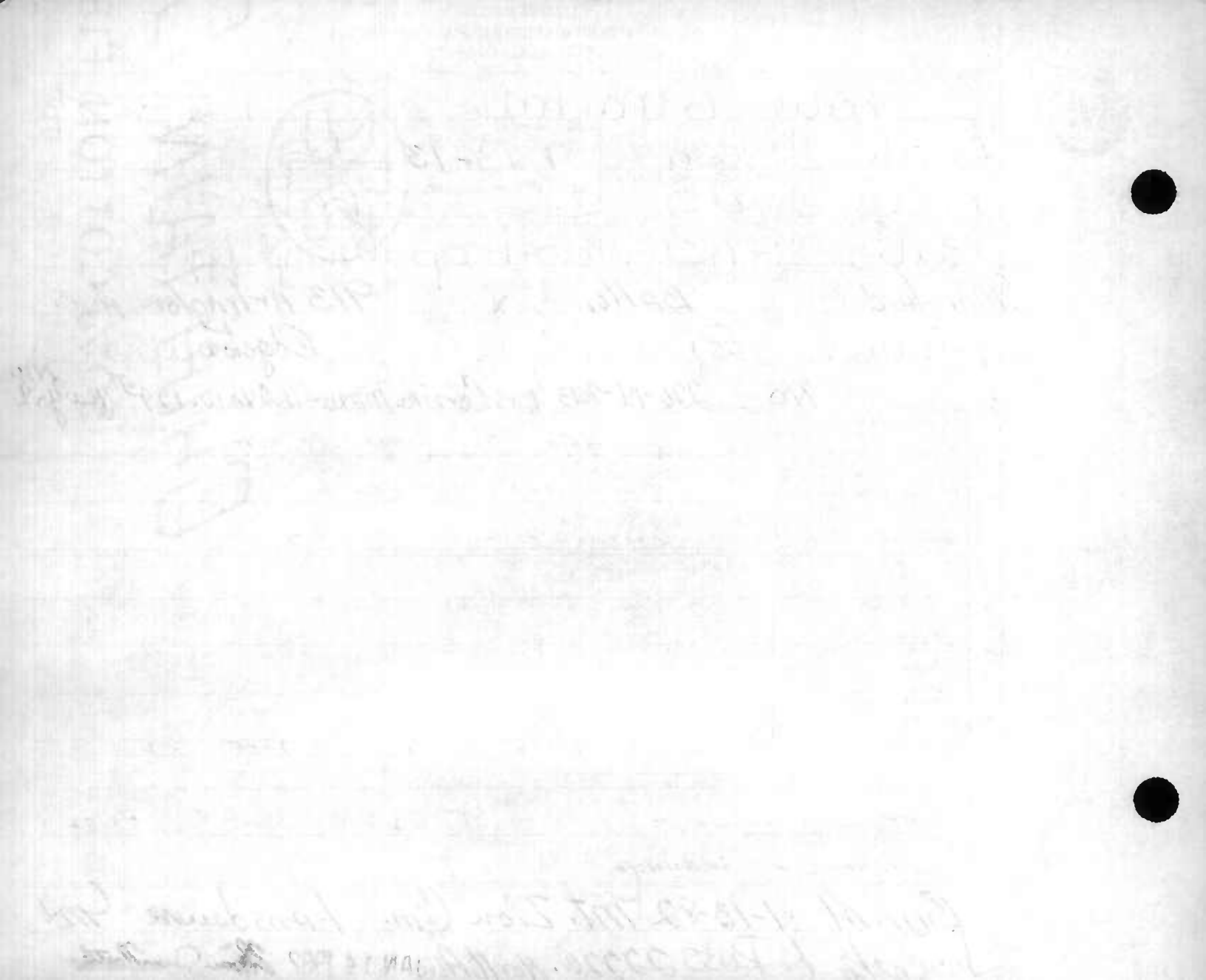
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |   |  | REG. NO.   |   |                                   |
|--|--|--|--|---|--|---|--|---|--|--|---|-----------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Katie B Marshall</b>  |  |  |  |   | 2a. DATE OF DEATH  |   | MONTH  | DAY   | YEAR   | 2b. HOUR   |   |                                   |
| 3. SEX <b>Female</b>   |  |  |  |   | 4. RACE <b>Black</b>   |   | 5. DATE OF BIRTH   |   | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | MONTHS  |                                   |
| 7. BIRTHPLACE (COUNTRY) <b>Me. Cal.</b>  |  |  |  |   | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto City</b>                                       |  | MD.   |                                   |
| 10. CITY OR TOWN OF DEATH <b>Balto</b>   |  |  |  |   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>B'n Scunus Hosp.</b> |   |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Unemployed</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>Maryland</b>   |  |  |  |   | 13b. COUNTY <b>BALTO.</b>  |   | 13c. CITY OR TOWN <b>BALTO.</b>  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <b>913 Arlington Ave.</b> |                                   |
| 14. FATHER'S NAME <b>Finner</b>  |  |  |  |   | 15. MOTHER'S MAIDEN NAME <b>Betty Edgetown</b>   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>  |   | 16b. SOCIAL SECURITY NO. <b>226-14-7013</b>  |  | 17. INFORMANT <b>Mrs. Corrine Maxwell</b>     |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |   |  |   |  |  |   |                                   |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |   |  |   |  |   |  |  |   |                                   |
| IMMEDIATE CAUSE (a) <b>Hepatic &amp; renal failure</b>   |  |  |  |   |  |   |  |   |  |  |   |                                   |
| 5733   |  |  |  |   |  |   |  |   |  |  |   |                                   |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |  |   |  |   |  |  |   |                                   |
| (b) <b>Pulmonary Hepatitis</b>   |  |  |  |   |  |   |  |   |  |  |   |                                   |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |  |   |  |   |  |  |   |                                   |
| (c) <b>Gastric Perforation Bleeding</b>  |  |  |  |   |  |   |  |   |  |  |   |                                   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1   |  |  |  |   |  |   |  |   |  |  |   |                                   |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |                                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)    |  |  |   |                                   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                    |  |  |   |                                   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12-16</b> , 19 <b>81</b> , to <b>1-7-82</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |   |  |  |   |                                   |
| 22b. SIGNATURE <b>Arlene A. Sabunsky</b>   |  |  |  | DEGREE  |  |   |  | 22c. DATE SIGNED <b>1/8/82</b>  |  |  |   |                                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Arlene A. Sabunsky</b>  |  |  |  | 22e. ADDRESS  |  |   |  |   |  |  |   |                                   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>  |  |  |  | 23b. DATE <b>1-13-82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion Cem.</b> |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Lansdowne Md.</b>                      |  |  |   |                                   |
| 24. FUNERAL DIRECTOR NAME <b>Joseph L. Russ</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>JAN 14 1982</b>                    |  |   |  | 25b. REGISTRAR'S SIGNATURE <b>John J. [Signature]</b>                             |  |  |   |                                   |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

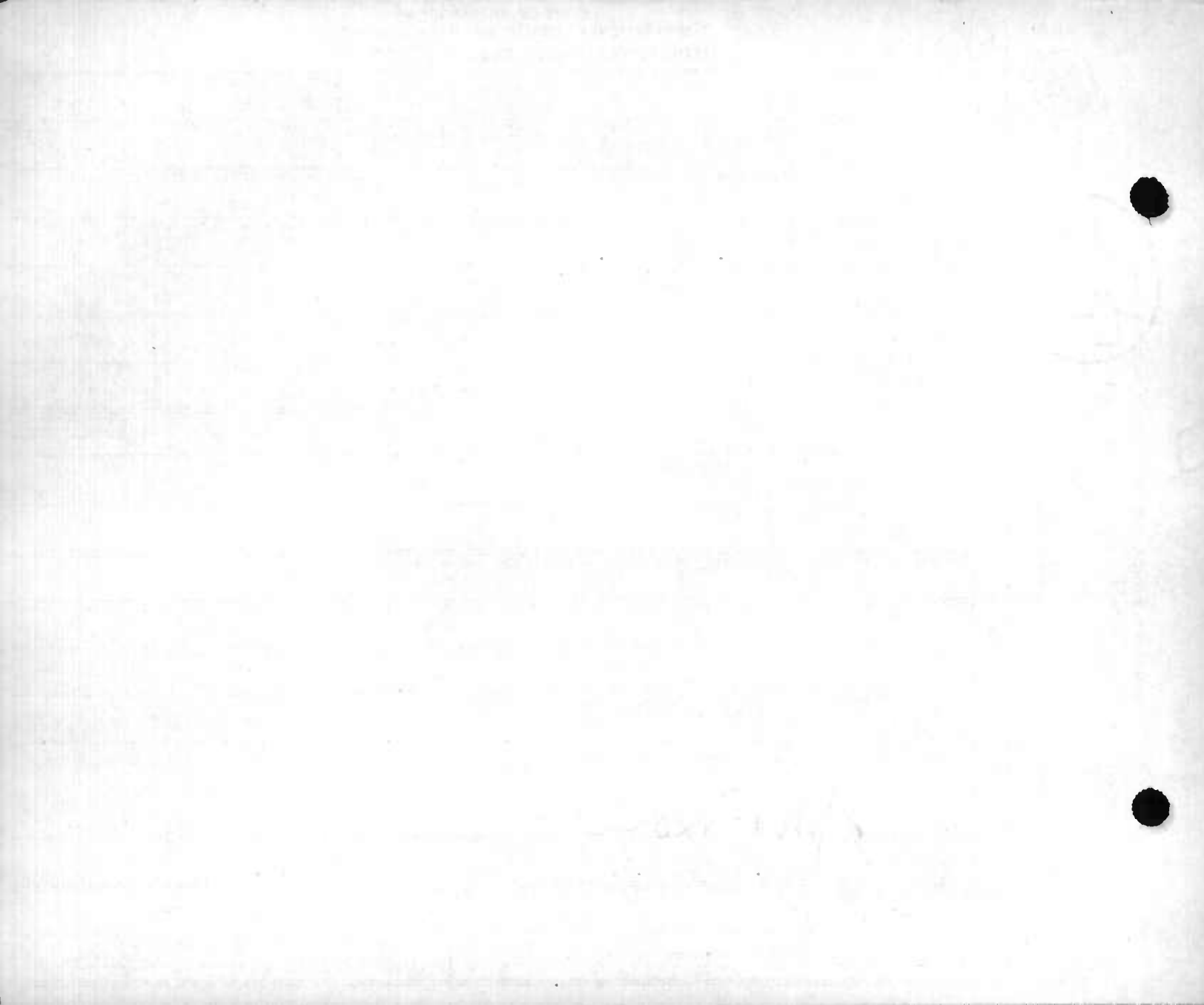
DHMH-17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |                  |  |  |   |  |  |   |   |
|--|------------------|--|--|---|--|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>VICTORIA A. (MARSHAL) MARSHALL  |                  |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED<br>1 14 19 82                   |   |  | 2b. HOUR<br>2:42   |   |   |
| 3. SEX<br>female   | 4. RACE<br>negro | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4 2 75   | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br>6 YRS.                       | IF UNDER 1 YR.<br>MONTHS DAYS   | IF UNDER 24 HRS.<br>HOURS MIN.   | 2c. DATE PRONOUNCED DEAD<br>1 14 19 82                         |   |   |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.     |   |   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>8 S. Carey St. |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |   | 12b. KIND OF BUSINESS OR INDUSTRY                         |
| 13a. STATE<br>MD   |                  |  | 13b. COUNTY<br>Baltimore   |   | 13c. CITY OR TOWN<br>Baltimore   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>George Marshall  |                  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Caroline Clark      |   |  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No  |                  | (IF YES, GIVE WAR OR DATES)  |  | 16b. SOCIAL SECURITY NO.<br>N/A   |  | 17. INFORMANT<br>ADDRESS<br>Caroline Marshall 1202 Bayard St.  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Smoke inhalation</u><br>9680<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF   |                  |  |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH              |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |                  |  |  |   |  |  |   |   |
| 19a. DATE OF OPERATION   |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                    |   |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |   |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>1:50xx 1-14- 1982 |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)<br>House fire. |  |   |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK AT WORK   |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>house |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>8 S. Carey St. Baltimore Co. Md.        |  |   |   |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> |                  |  |  |   |  |  |   |   |
| ACTUAL SIGNATURE<br><i>Ann M. Dixon</i>  |                  |  | TITLE (SPECIFY)<br>M.D. Assistant                                    |   |  | DATE SIGNED<br>1-14-82   |   |   |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Ann M. Dixon, M.D.   |                  |  | ADDRESS<br>111 Penn St.  |   |  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |                  | 23b. DATE<br>1/19/82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview Mem. Pk.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Co. MD |   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H   |                  |  |  | ADDRESS<br>1101 E. North Ave.   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 18 1982                   |   | 25b. REGISTRAR'S SIGNATURE<br><i>James J. [Signature]</i> |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 2 4 4

REG. NO.

|  |   |  |  |   |  |
|--|---|--|--|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>FIRMA A. MARTELLO</b>  |   |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 14 82</b>   |   | 2b HOUR<br><b>4 A M</b>  |
| 3 SEX<br><b>Female</b>   | 4 RACE<br><b>White</b>  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>January 17, 1901</b>   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Austria</b>   | 7b CITIZEN OF WHAT COUNTRY?<br><b>Italy</b>   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>City</b> MD.                                       |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Good Samaritan Hospital</b> |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>          |   | 12b. KIND OF BUSINESS OR INDUSTRY  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |   | 13a. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  | 13b. STREET ADDRESS<br><b>1235 Evesham Avenue</b>  |   |  |
| 13a STATE<br><b>Md.</b>  | 13b COUNTY  | 13c CITY OR TOWN<br><b>Baltimore</b>   |  |   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Augustino Maturi</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lidwina Coll</b>   |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>no</b>   |   | 16b SOCIAL SECURITY NO.<br><b>216-32-9912</b>  | 17. INFORMANT ADDRESS<br><b>Mr. John C. Martello Sr. 8 Kings Crossing Ct</b>                 |   |  |
| 18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Progressive renal failure</b><br>4039<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>ARTERIAL HYPERTENSION</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>CEREBRAL VASCULAR DISEASE</b> |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a<br><b>PARKINSON'S DISEASE</b>   |   |  |  |   |  |
| 19a DATE OF OPERATION<br><b>-</b>  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>-</b>   |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)               |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12-18-81</b> , 19 <b>81</b> , to <b>1/14</b> , 19 <b>82</b> , that (I) (we) lost<br>saw the deceased alive on <b>1/13/82</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                    |   |  |  |   |  |
| 22b. SIGNATURE<br><b>Antonio Sergio Conway MD</b><br>DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>  |   |  |  | 22c. DATE SIGNED<br><b>1/14/82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Antonio S. CASSANEGO</b>   |   |  | 22e ADDRESS<br><b>5601 LOCH RAVEN BLVD</b>   |   |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |   | 23b. DATE<br><b>Jan. 16, 1982</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley</b>                                  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Cockeysville Balto. Md.</b>   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Leonard J. Ruck Inc. Baltimore, Maryland</b>  |   |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR<br><b>JAN 19 1982</b> <b>Charles Jan Nathan</b> |   |  |



COPIES OF THE  
REPORT

JAN 10 1965  
J. H. H. H.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM 1. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                         |  |  |   |                                |   |                                 |   |  | REG. NO. 01245  |  |
|--|-------------------------|--|--|---|--------------------------------|---|---------------------------------|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>BERNARD LEWIS MARTIN</b>   |                         |  |  |   |                                |   |                                 |   |  | 2a. DATE KNOWN OF DEATH<br>MONTH DAY YEAR<br><b>1 17 82</b> |  |
| 3. SEX<br><b>male</b>  | 4. RACE<br><b>white</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 18 17 64</b> YRS.  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br>MONTHS DAYS HOURS MIN.<br><b>64</b> YRS. | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | IF UNDER 24 HRS.<br>HOURS MIN. | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>1 17 82</b>                                    | 2d. HOUR<br>M<br><b>3:45 PM</b> |   |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |                                 |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>803 W. Cross Street</b> |  |   |                                | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Self-Employed</b>           |                                 |   |  |   |  |
| 13a. STATE<br><b>Md.</b>   |                         | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |                                | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                 |   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Stonewall Jackson Martin</b>  |                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ella Lou Davis</b>   |  | 13e. STREET ADDRESS<br><b>803 W. Cross St.</b>  |                                |   |                                 |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>   |                         | 16b. SOCIAL SECURITY NO.<br><b>227-14-9445</b>   |  | 17. INFORMANT ADDRESS<br><b>Kathy Collins 3952 McDowell La.</b>   |                                |   |                                 |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.  |                         |  |  |   |                                |   |                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |                         |  |  |   |                                |   |                                 |   |  |   |  |
| 19a. DATE OF OPERATION   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |                                | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |                                 |   |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |                                |   |                                 |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                |   |                                 |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                         |  |  |   |                                |   |                                 | TITLE (SPECIFY)<br>DATE SIGNED <b>1/18/82</b> |  |   |  |
| ACTUAL SIGNATURE<br><b>Ann M. Dixon</b>  |                         | M.D. <b>Assistant</b> MEDICAL EXAMINER   |  |   |                                | DATE SIGNED <b>1/18/82</b>  |                                 |   |  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Ann M. Dixon, M.D.</b>  |                         | ADDRESS <b>111 Penn Street, Balto. MD 21201</b>  |  |   |                                |   |                                 |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |                         | 23b. DATE<br><b>1/22/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn Cemetery</b>  |                                | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md</b>                               |                                 |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>B. Dabrowski &amp; Son 2818 E. Baltimore St.</b>  |                         |  |  | 25a. DATE REC'D. BY REGISTRAR   |                                | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |                                 |   |  |   |  |

JAN 25 1982



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Items 5, 6 g563 1/18/82 gj

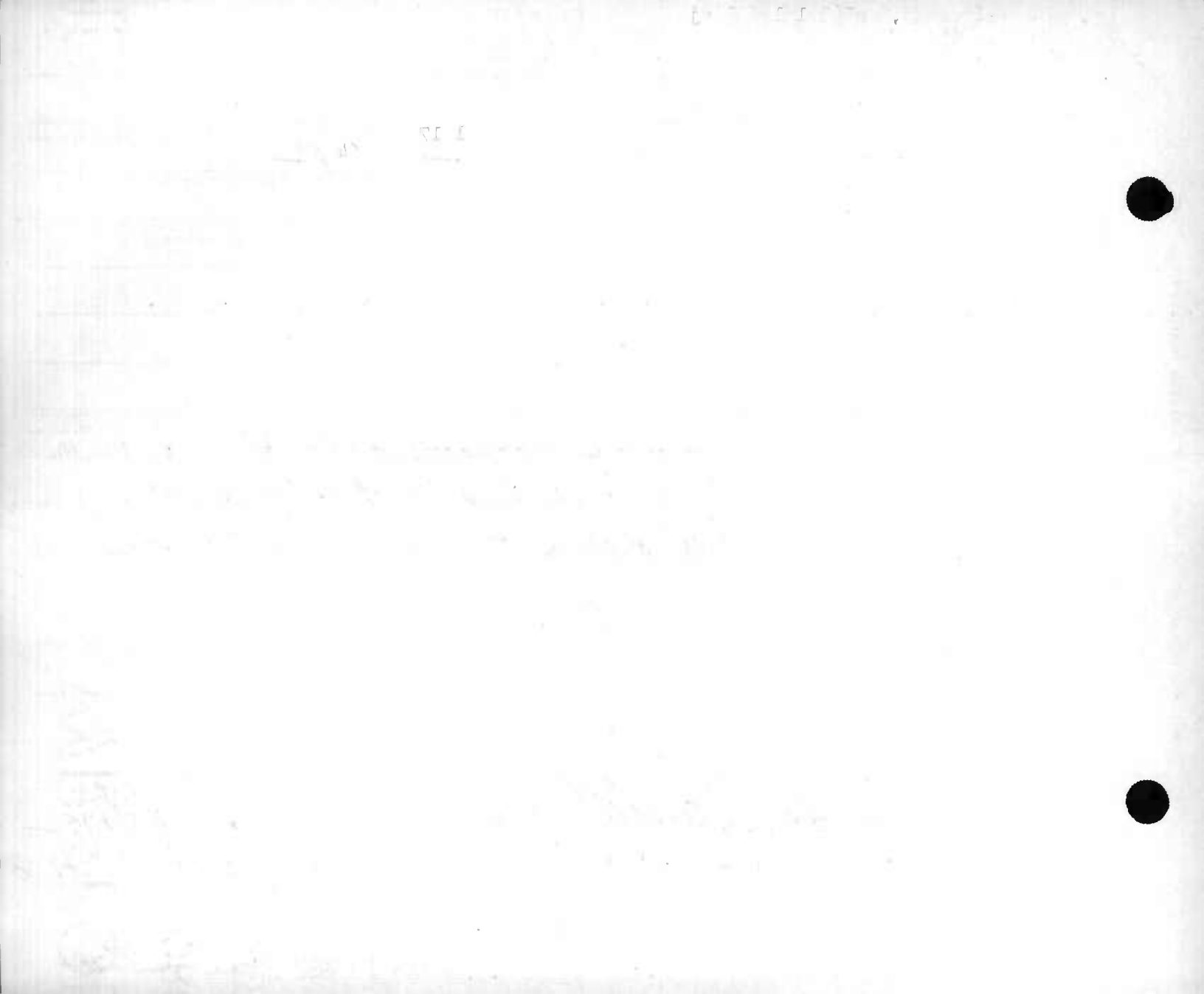
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 8 2 0 1 2 4 6

|  |   |   |  |  |   |
|--|---|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Estelle E. Mason</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 7, 1982</b>  |  | 2b. HOUR<br>M<br><b>AM</b>                                  |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>Black</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 10 1917</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b> YRS   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>66</b>                 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NORTH CAROLINA</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>631 Cheraton Road</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>MONTGOMERY WARD</b> |
| 13a. STATE<br><b>MD</b>  | 13b. COUNTY   | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  | 13e. STREET ADDRESS<br><b>631 Cheraton Rd.</b>   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>BENJAMIN BOWSER</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>EMILY HAMIL</b>   |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>240-26-5429</b>   | 17. INFORMANT ADDRESS<br><b>SAMUEL MASON 631 CHERATON RD.</b>   |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiopulmonary arrest</b><br>4140<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>congestive heart failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>hypertensive arteriosclerotic heart disease</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>instantaneous</b><br><b>Many years</b> |   |   |  |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).  |   |   |  |  |   |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) visit the body after death.  |   |   |  |  |   |
| 22b. SIGNATURE<br><b>T. Joseph Mardelli MD</b>   |   | DEGREE<br><b>MD</b>   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED<br><b>1/8/1982</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>T. JOSEPH MARDELLI</b>   |   | 22e. ADDRESS<br><b>3001 S. Hanover Bal MD 21230</b>   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   | 23b. DATE<br><b>1/12/82</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CEDAR HILL CEM</b>   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO MD</b>  |  |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H 1101 E. North Ave.</b>   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 11 1982</b>  | 25b. REGISTRAR'S SIGNATURE<br><b>Frances Jean Nathan</b>   |   |

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DHMH-16 20M  
(VRA 15, 4) 7/78



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

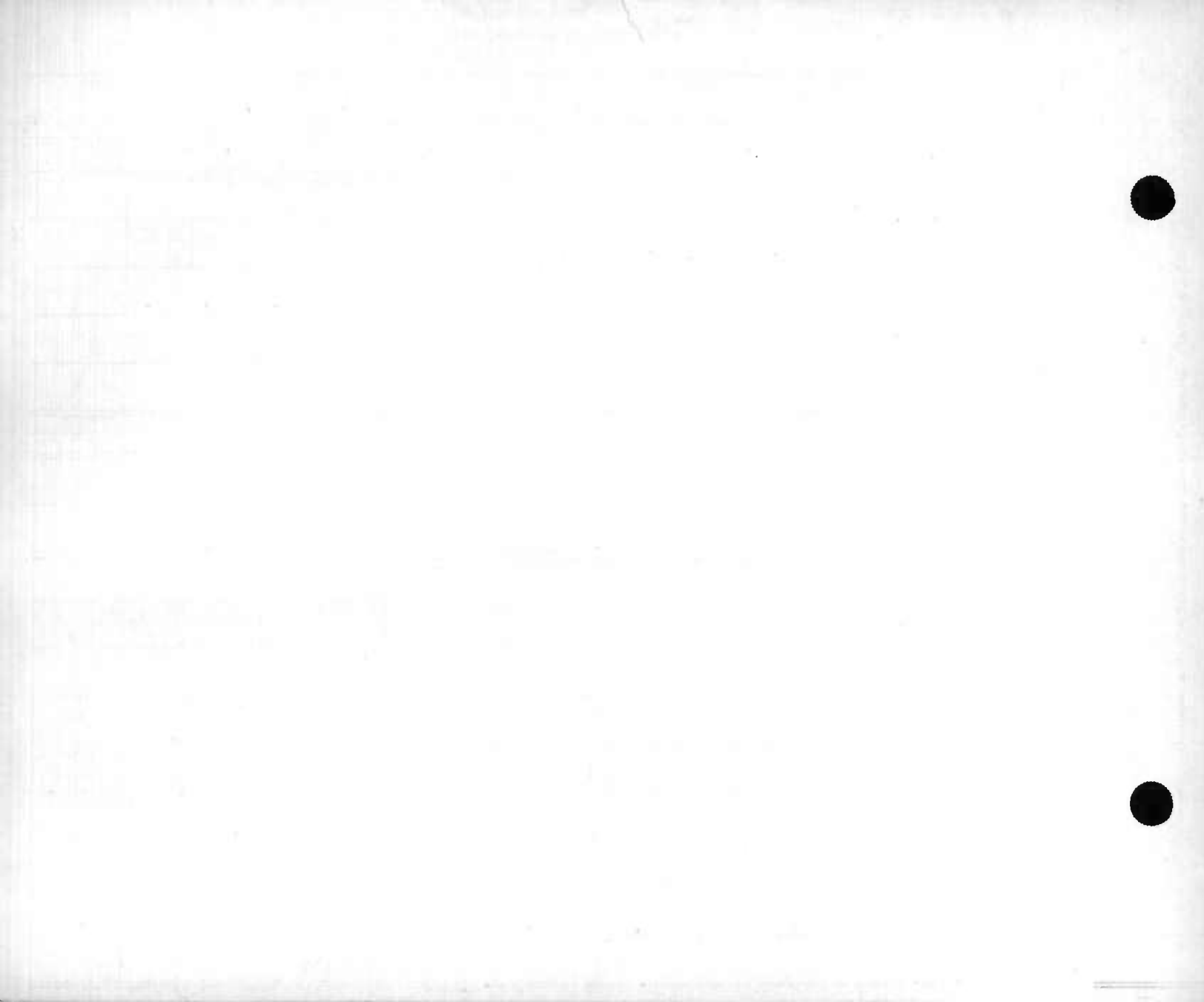
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 8 2 0 1 2 4 7   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Rufus Mason   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>January 7, 1982   |  |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>Black   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 12 08  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>73 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>NORTH CAROLINA  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1712 N. Bond Street |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>RETIRED   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>construction  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| 13a. STATE<br>MD   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13e. STREET ADDRESS<br>1712 N. Bond St.  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>FRED MASON   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MARIE CURETON  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>240-14-0349   |  | 17. INFORMANT ADDRESS<br>EMMA B. MASON 1712 N. BOND ST  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardio respiratory Arrest</u><br>1919<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Increased Intracranial Pressure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Brain Tumor (Glioblastoma)</u>                      |  |  |  |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>1/7/81 PM |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION<br>10/81  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Brain Tumor  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12</u> 19 <u>81</u> , to <u>10/7</u> 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>12</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br>Noel Tulpa   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Noel Tulpa  |  |  |  | 22e. ADDRESS<br>Johns Hopkins   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  | 23b. DATE<br>1/13/82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>BALTO. CEMETERY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO. MD.   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Wm. C. March F/H 1101 E. North Ave.  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 11 1982  |  | 25b. REGISTRAR'S SIGNATURE<br>Charles J. Walker  |  |

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DHMH-16 20M  
(VRA 15, 4) 7/78



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item #1 Film G567 5/26/82rc

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 2 4 8

|  |  |  |  |  |      |
|--|--|--|--|--|------|
| 1. FOR STATE REGISTRAR   |  | 2a. DATE OF DEATH  |  | 2b. HOUR   |      |
| 1. DECEASED NAME (TYPE OR PRINT) <b>Danielle Marie</b>   |  | MONTH DAY YEAR <b>1-16-82</b>  |  | 8:35 A.M.  |      |
| 3. SEX <b>female</b>   | 4. RACE <b>Caucasian</b>   | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY)                                | IF UNDER 1 YEAR  |      |
|  |  | MONTH DAY YEAR <b>1 16 82</b>  | <b>0</b>   | MONTHS   | DAYS |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD. |  |      |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Agnes Hospital</b> | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>none</b>  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |      |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   | 13b. CITY OR TOWN  | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 13d. STREET ADDRESS  |  |      |
| 13a. STATE <b>Md</b>   | 13b. COUNTY <b>Balto</b>   |  | <b>30 Darrow Drive</b>   |  |      |
| 14. FATHER'S NAME  | 15. MOTHER'S MAIDEN NAME   | 16. SOCIAL SECURITY NO.  |  |  |      |
| FIRST MIDDLE LAST <b>MARK D. MASSEY</b>  | FIRST MIDDLE LAST <b>LORI J. MASSEY</b>  | <b>none</b>  |  |  |      |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  | 16b. SOCIAL SECURITY NO.   | 17. INFORMANT ADDRESS  |  |  |      |
| <b>no</b>  | <b>none</b>  | <b>Mr. Mark D. Massey, 30 Darrow Rd. 21228</b>   |  |  |      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:  |  |  |  |  |      |
| IMMEDIATE CAUSE (a) <b>prematurity</b>   |  |  |  |  |      |
| DUE TO, OR AS A CONSEQUENCE OF (b)   |  |  |  |  |      |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |  |      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |  |      |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>         |      |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  |      |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |      |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |      |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8-16-82</b> to <b>8-16-82</b> , that (I) (we) last saw the deceased alive on <b>8-16-82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |      |
| 22b. SIGNATURE <b>Wen-King Huang M.D.</b>  |  | DEGREE   |  | 22c. DATE SIGNED   |      |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Wen-King Huang M.D.</b>   |  | 22e. ADDRESS   |  |  |      |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>  |  | 23b. DATE <b>1/22/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>NEW CATHEDRAL</b>                        |      |
| 23d. LOCATION CITY OR TOWN COUNTY STATE <b>4300 OLD FREDK. RD. BALTO. 21229</b>  |  |  |  |  |      |
| 24. FUNERAL DIRECTOR NAME ADDRESS <b>WITZKE FUN" LHOME 1630 EDMONDSON AVE. BALTO</b>   |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR SIGNATURE <b>James J. Nathan</b>  |  |  |      |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 2 4 9

REG. NO.

|   |  |  |  |   |  |  |   |   |   |   |  |
|---|--|--|--|---|--|--|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>BETTIE M MATTHEWS</b>  |  |  | 2a. DATE OF DEATH<br>MONTH <b>01</b> DAY <b>18</b> YEAR <b>82</b>      |   |  | 2b. HOUR<br><b>11 45 AM</b>  |   |   |   |   |  |
| 3. SEX<br><b>F</b>  |  | 4. RACE<br><b>N</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>08</b> DAY <b>26</b> YEAR <b>33</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>48</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>  |   | IF UNDER 24 HRS<br>HOURS <b></b> MIN. <b></b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>US</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALT. CITY</b> MD.  |   |   |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALT.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>NCHH</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HW</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY   |   |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>2200 ST PAUL ST</b>  |   |   |   |   |  |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>BALT</b>  |  |  |   |   |   |   |  |
| 14. FATHER'S NAME<br>FIRST <b>Ardes</b> MIDDLE <b></b> LAST <b>Pridgen</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Bettie</b> MIDDLE <b></b> LAST <b>DAVIS</b>  |  |  |   |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>218-28-8807</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Walter Matthews 2200 St. Paul St.</b>  |  |  |   |   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY FAILURE</b><br><b>1509</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Esophagus</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>CA BRONCHUS &amp; METASTASIS</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>CA Esophagus.</b> (c) |  |  |  |   |  |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |  |   |   |   |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>      |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 2)   |   |   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/16/82</b> , 19 <b>82</b> , to <b>1/18/82</b> , 19 <b>82</b> , that (I) (we) lost<br>saw the deceased alive on <b>1/18/82</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |   |   |   |   |  |
| 22b. SIGNATURE<br><b>Wm C March</b>   |  |  | DEGREE<br><b>MD</b>  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |   | 22c. DATE SIGNED<br><b>1/18/82</b>                  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Wm C March</b>  |  |  | 22e. ADDRESS<br><b>NCHH</b>  |   |  |  |   |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>  |  |  | 23b. DATE<br><b>1/22/82</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Md. Vet. Cem.</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Crownsville, Md.</b> |   |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm C March F/H</b>   |  |  |  |   |  | ADDRESS<br><b>1101 E. North Ave.</b>   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 21 1982</b> |   |  |
|   |  |  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |   |   |   |   |  |

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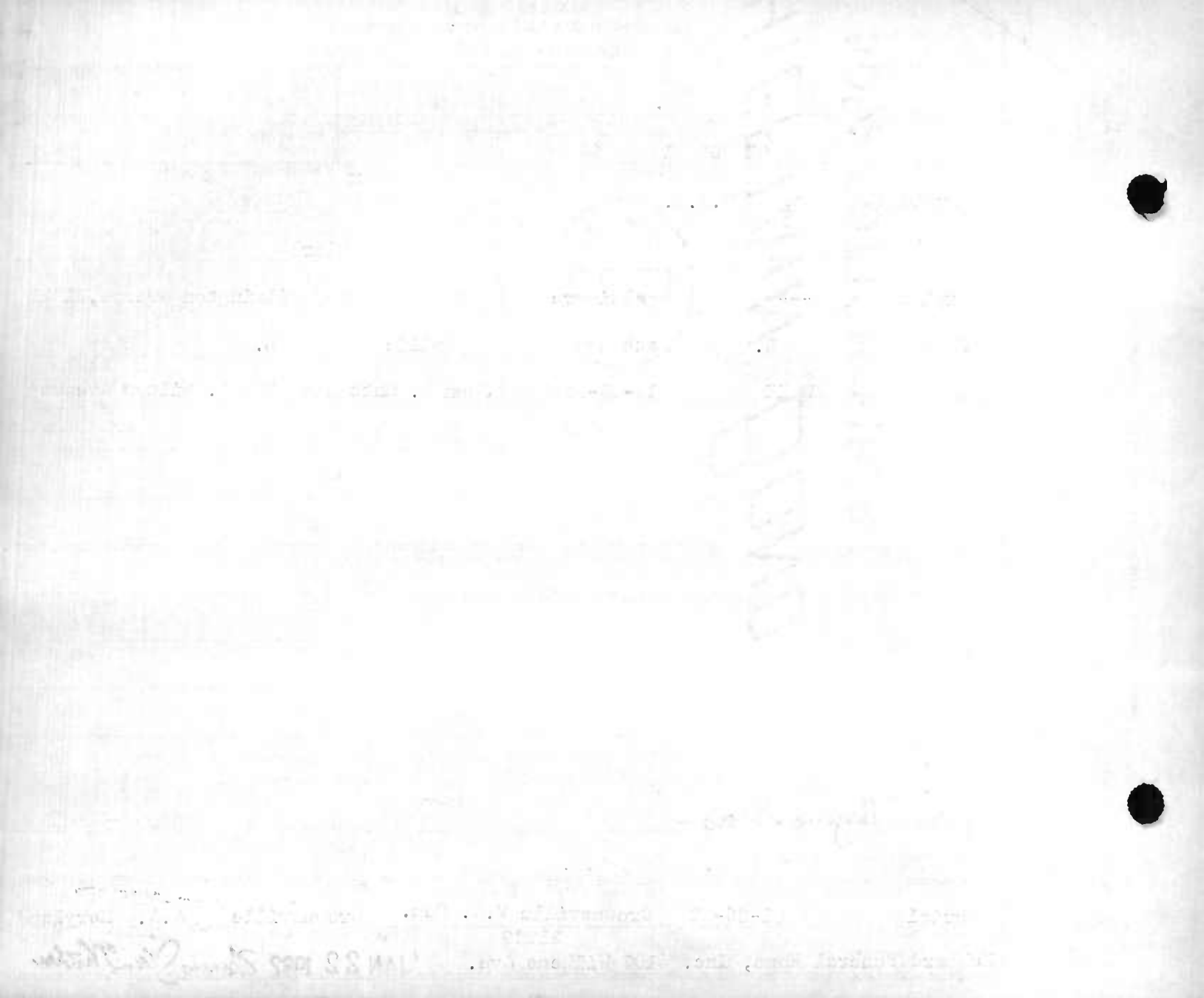
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |                  |   |  |   |                               |   |  |   |  | REG. NO. 01250  |  |                        |
|---|------------------|---|--|---|-------------------------------|---|--|---|--|---|--|------------------------|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Russell L. Matthews   |                  |   |  |   |                               |   |  |   |  | 2a. DATE KNOWN OF DEATH<br>MONTH DAY YEAR<br>XX 1 19 82 |  | 2b. HOUR<br>M<br>12:25 |
| 3. SEX<br>Male  | 4. RACE<br>White | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>02 02 15  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>66 YRS. | IF UNDER 1 YR.<br>MONTHS DAYS   | IF UNDER 24 HRS.<br>HOURS MIN | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>1 20 1982   |  | 2d. HOUR<br>M<br>12:25  |  |   |  |                        |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                               | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                                     |  |   |  |   |  |                        |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>905 Wilmington Avenue |  |   |                               | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Clerk                          |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |                        |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |                  |   |  |   |                               |   |  |   |  |   |  |                        |
| 13a. STATE<br>Maryland  |                  | 13b. COUNTY<br>---  |  | 13c. CITY OR TOWN<br>Baltimore  |                               | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>905 Wilmington Avenue, 21223                                 |  |   |  |                        |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John L. Matthews  |                  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mollie L. Ekas   |                               |   |  |   |  |   |  |                        |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>Yes  |                  | (IF YES, GIVE WAR OR DATES)<br>WW II  |  | 16b. SOCIAL SECURITY NO.<br>214-03-9947   |                               | 17. INFORMANT ADDRESS<br>John D. Matthews 704 S. Hilton Avenue 21228                            |  |   |  |   |  |                        |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease<br>4292<br>(b) _____<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). |                  |   |  |   |                               |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH            |  |                        |
| MEDICAL CERTIFICATION   |                  |   |  |   |                               |   |  |   |  |   |  |                        |
| 19a. DATE OF OPERATION  |                  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |                               |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |                        |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |                               |   |  |   |  |   |  |                        |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                               |   |  |   |  |   |  |                        |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .          |                  |   |  |   |                               |   |  |   |  |   |  |                        |
| ACTUAL SIGNATURE<br>Virginia L. Dolan   |                  |   |  | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER  |                               |   |  | DATE SIGNED<br>1-20-82  |  |   |  |                        |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Virginia L. Dolan, M.D.  |                  |   |  | ADDRESS<br>111 Penn Street  |                               |   |  |   |  |   |  |                        |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |                  | 23b. DATE<br>01-26-82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Crownsville V.A. Cem.   |                               | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Crownsville A.A. Maryland                         |  |   |  |   |  |                        |
| 24. FUNERAL DIRECTOR<br>NAME<br>Hubbard Funeral Home, Inc.  |                  |   |  | ADDRESS<br>4107 Wilkens Ave.  |                               | 25a. DATE REC'D. BY REGISTRAR<br>JAN 22 1982  |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Van Natten                                    |  |   |  |                        |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |                   |  | 8 2 0 1 2 5 1   |     |            |          |
|---|--|--|--|--|--|--|--|-------------------|--|---|-----|------------|----------|
| 1. FOR STATE REGISTRAR  |  | REG. NO.   |  |  |  |  |  |                   |  |   |     |            |          |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST  |  | MIDDLE   |  | LAST   |  | 2a. DATE OF DEATH |  | MONTH   | DAY | YEAR       | 2b. HOUR |
| MARY Colley   |  | MAX  |  | FIELD  |  |  |  | 11                |  | 7   | 82  | 2:35 AM    |          |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                |  | IF UNDER 1 YEAR   |  | IF UNDER 24 HRS   |     |            |          |
| 1-FEMALE  |  | WHITE  |  | 12/03/95   |  | 86 YRS   |  | MONTHS            |  | DAYS  |     | HOURS MIN. |          |
| 7a. BIRTHPLACE (COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |  |                   |  |   |     |            |          |
| MD.   |  | U.S.A.   |  |  |  | BALTS. CITY.   |  |                   |  |   |     | MD.        |          |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION  |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |                   |  |   |     |            |          |
| BALTIMORE   |  | BON SECOURS  |  | RETIRED  |  | HOMEMAKER  |  |                   |  |   |     |            |          |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13b. COUNTY  |  | 13c. INSIDE CITY LIMITS?   |  | 13d. STREET ADDRESS  |  |                   |  |   |     |            |          |
| MD.   |  | AA Co.   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 210 D. St.   |  | 21061             |  |   |     |            |          |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |                   |  |   |     |            |          |
| George Washington Strawinski  |  | Mary   |  |  |  |  |  |                   |  |   |     |            |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | ADDRESS  |  |                   |  |   |     |            |          |
| NO  |  | 212.30.9208D   |  | Doris R. Burkmar   |  | 5 Brownshade Dr.   |  | Glen Burnie, Md.  |  | 21061   |     |            |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY</u> <u>ARREST</u>  |  |  |  |  |  |  |  |                   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>few minutes</u> |     |            |          |
| 4279 } DUE TO, OR AS A CONSEQUENCE OF (b) <u>CARDIAC</u> <u>ARRHYTHMIA</u>  |  |  |  |  |  |  |  |                   |  |   |     |            |          |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |  |  |  |  |                   |  |   |     |            |          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>EMPHYSEMA GALL BLADDER WITH PERFORATION.</u>  |  |  |  |  |  |  |  |                   |  |   |     |            |          |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |                   |  |   |     |            |          |
| 11-4-81   |  | EMPHYSEMA GALL BLADDER   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |                   |  |   |     |            |          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED   |  |  |  |                   |  |   |     |            |          |
|   |  | HOUR A.M. MONTH DAY YEAR   |  | P.M. — 19  |  |  |  |                   |  |   |     |            |          |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY   |  | 21f. LOCATION  |  |  |  |                   |  |   |     |            |          |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | (AT HOME STREET FACTORY OFFICE FARM ETC.)  |  | STREET   |  | CITY OR TOWN   |  | COUNTY            |  | STATE   |     |            |          |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11-4-</u> <u>1981</u> to <u>1-7-</u> <u>1982</u> , that (I) (we) lost <u>saw</u> the deceased alive on <u>1-7-</u> <u>1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |                   |  |   |     |            |          |
| 22b. SIGNATURE  |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 22c. DATE SIGNED   |  |                   |  |   |     |            |          |
| <u>Surjit S. Julka</u>  |  |  |  |  |  | <u>1-7-82</u>  |  |                   |  |   |     |            |          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |  |  |  |  |                   |  |   |     |            |          |
| SURJIT S JULKA  |  | BON SECOURS HOSPITAL, BALTIMORE  |  |  |  |  |  |                   |  |   |     |            |          |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION  |  |                   |  |   |     |            |          |
| Cremation   |  | 1/8/1982   |  | Green Mount Cemetery   |  | Baltimore  |  | COUNTY            |  | STATE   |     | Maryland   |          |
| 24. FUNERAL DIRECTOR  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |                   |  |   |     |            |          |
| Walter Brooks Bradley Inc, Balto. Md. 21222   |  | JAN 11 1982  |  | <u>Frances Jean Nathan</u>   |  |  |  |                   |  |   |     |            |          |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |   |  | REG. NO.  |  |  |  |
|--|--|--|--|--|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>Jessie May</b>   |  |  |  |  |  |  |  |   |  | 2b. DATE OF DEATH MONTH DAY YEAR 01 31 82   |  |  |  |
| 3 SEX <b>Female</b>  |  | 4. RACE <b>White</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR 1 8 91   |  | 6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS                                   |  | IF UNDER 1 YEAR MONTHS DAYS   |  | IF UNDER 24 HRS HOURS MIN.  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN) <b>Poland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                                 |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto C.H.</b> MD.               |  |   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>CR TA N. H.</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>N/A</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |  |  |
| 13a. STATE <b>md</b> 13b. COUNTY <b>Balto.</b> 13c. CITY OR TOWN <b>Balto.</b>   |  |  |  |  |  |  |  |   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  | 13e. STREET ADDRESS <b>6810 Youngstown Ave., 21222</b> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Michael Kwasi Kwasi</b>   |  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Josephine Prater Rowland</b> |  |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS <b>Agnes Rowland 6810 Youngstown Ave.</b>  |  |  |  |   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro-vascular accident</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Diabetes Mellitus</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>2500</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |  |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |  |  |  |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                 |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11-3</b> 19 <b>81</b> , to <b>1-31</b> 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>1-31-82</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.      |  |  |  |  |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE <b>R. O. Croasley</b>   |  |  |  | DEGREE   |  |  |  | 22c. DATE SIGNED  |  |   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>R. O. CROASLEY</b>  |  |  |  | 22e. ADDRESS <b>1235 E. Monument St Baltimore Md</b>   |  |  |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>  |  |  |  | 23b. DATE <b>2-4-82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>S.H. of Jesus</b>                  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md</b>                                   |  |   |  |  |  |
| 24. FUNERAL DIRECTOR NAME <b>KACZOROWSKI F. H.</b>   |  |  |  | ADDRESS <b>2525 Fleet St</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>FEB 2 1982 Thomas Jan Thirion</b> |  |   |  |  |  |

FEB 3 1985

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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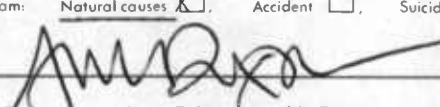

DHMH - 16 50M 1/81  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |   |  |   |  |  |  |  |
|--|--|---|--|---|--|---|--|--|--|--|
| CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |  |  |  |
| 1. FOR STATE REGISTRAR   |  |   |  |   | REG. NO.   |   |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>HOMER E MCCANN</b>  |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>1-3-82</b>                    |   |  |  |  | 2b. HOUR<br><b>3:45 M</b>  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>C</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>8 4 07</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b>  |  | 7. IF UNDER 1 YEAR (MONTHS) DAYS<br><b>74</b> YRS.   |  | 8. IF UNDER 24 HRS. (HOURS) MIN.<br><b>45</b>  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N. Carolina</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto City</b> MD  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto City</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University Hosp.</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret. Purchasing Agent-</b>                    |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Merritt Corp.</b>  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE<br><b>Md.</b>   |  |   |  |   | 13c. CITY OR TOWN<br><b>Calvert</b>                                  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>Box 376 C Ward Rd. - Rt. 4</b> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Wessley M. McCann</b>  |  |   |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Mary R. Osborne</b> |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br><b>-</b>  |  | 17. INFORMANT<br><b>Zelma A. McCann (above address)</b>   |  | ADDRESS<br><b>(Wife)</b>  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Irreversible Brain Injury</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Acute Subdural Hematoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Skull Fracture</b> |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>12h</b><br><b>12h</b><br><b>12h</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>7 9160</b>  |  |   |  |   |  |   |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>1-2-82</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Acute Subdural Hematoma</b>  |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                 |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><b>21</b>   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>1-2 1982</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>helping to cut logs free when they fell on him</b>                     |  | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK |  |  |  |  |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>home</b>   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1-2</b> 19 <b>82</b> to <b>1-3</b> 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>1-3</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |  |  |  |
| 22b. SIGNATURE<br><b>Almeen L. Ramsey M.D.</b>   |  |   |  |   | DEGREE<br><b>MD</b>  |   | 22c. DATE SIGNED<br><b>1-3-82</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   |  |   | 22e. ADDRESS   |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>  |  | 23b. DATE<br><b>1/5/1982</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln Crematory</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Brentwood Pr. Geo. Md.</b>  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Nalley's F.H. Inc.</b>   |  |   |  |   | ADDRESS<br><b>Mt. Rainier, Md.</b>                                   |   | 25a. DATE RECD. BY REGISTRAR<br><b>JAN 11 1982</b>   |  |  |  |
|  |  |   |  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Frances Jean Nathan</b>             |   |  |  |  |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 2 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| 1- STATE REGISTRAR   |  |                         |  |   |  |  |  |   |  | MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |  |  | REG. NO.                          |  |
|--|--|-------------------------|--|---|--|--|--|---|--|--|--|---|--|---|--|--|--|--|--|-----------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>Lenard LEONARD</b>  |  |                         |  |   |  |  |  |   |  | 2a. DATE OF DEATH<br>KNOWN <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/><br>MONTH DAY YEAR<br><b>1 6 1982</b> |  |   |  |   |  |  |  |  |  | 2b. HOUR<br>M<br><b>1:55 P.M.</b> |  |
| 3. SEX<br><b>male</b>  |  | 4. RACE<br><b>negro</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 15 63</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>18 YRS.</b>              |  | 7. IF UNDER 1 YR.<br>MONTHS DAYS<br><b>0 0</b>  |  | 7. IF UNDER 24 HRS.<br>HOURS MIN.<br><b>0 0</b>  |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>1 6 1982</b>   |  | 2d. HOUR<br>P.M.<br><b>1:55 P.M.</b>  |  |  |  |  |  |                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>BALTIMORE</b>  |  |                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>   |  |   |  | MD   |  |  |  |                                   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  |                         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Provident Hospital</b> |  |  |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>STUDENT</b>  |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |  |  |                                   |  |
| 13a. STATE<br><b>MD</b>  |  |                         |  |   |  |  |  |   |  | 13b. COUNTY<br><b>BALTO.</b>   |  | 13c. CITY OR TOWN<br><b>BALTO.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>2814 WALBROOK AVE.</b> |  |  |  |                                   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JAMES McCLELLAN</b>   |  |                         |  |   |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>CARRIE GIVINS</b>  |  |   |  |   |  |  |  |  |  |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>NO</b>   |  |                         |  | (IF YES, GIVE WAR OR DATES)   |  | 16b. SOCIAL SECURITY NO.<br><b>N/A</b>                         |  | 17. INFORMANT<br>ADDRESS<br><b>JAMES McCLELLAN 2814 WALBROOK AVENUE</b>   |  |  |  |   |  |   |  |  |  |  |  |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral abscess (right frontal lobe)</b><br><b>3240 Intracerebral hematoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.                        |  |                         |  |   |  |  |  |   |  |  |  |   |  | 1. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |  |  |                                   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                         |  |   |  |  |  |   |  |  |  |   |  |   |  |  |  |  |  |                                   |  |
| 19a. DATE OF OPERATION   |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |   |  |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                 |  |   |  |  |  |  |  |                                   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |   |  |   |  |  |  |  |  |                                   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |   |  |  |  |  |  |                                   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                         |  |   |  |  |  |   |  |  |  |   |  |   |  |  |  |  |  |                                   |  |
| ACTUAL SIGNATURE    |  |                         |  |   |  |  |  |   |  | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER   |  |   |  | DATE SIGNED <b>1-7-82</b>   |  |  |  |  |  |                                   |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Ann M. Dixon, M.D.</b>   |  |                         |  |   |  |  |  |   |  | ADDRESS<br><b>111 Penn St.</b>   |  |   |  |   |  |  |  |  |  |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  |                         |  | 23b. DATE<br><b>1/12/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>WESTVIEW MEM. PK.</b> |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>CATONSVILLE, MD</b>   |  |   |  |   |  |  |  |  |  |                                   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>WM. C. MARCH F/H 1101 E. NORTH AVE.</b>   |  |                         |  |   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 11 1982</b>  |  | 25b. REGISTRAR'S SIGNATURE<br> |  |   |  |  |  |  |  |                                   |  |

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POSTAL TELEGRAPH  
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |  |   |  |  |
|---|--|---|--|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Pearl A Mc Cord</i>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>1-5-82</i> |   | 2b. HOUR<br><i>1:10 A.M.</i>   |   |  |  |
| 3. SEX<br><i>Female</i>   |  | 4. RACE<br><i>White</i>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>1 12 98</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>83</i> YRS.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Baltimore, Md.</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Balto. C. Ty</i> MD.                                 |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Lutheran Hospital</i> |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Retired</i>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Housework</i>  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |   |  |   |  |  |
| 13a. STATE<br><i>Maryland</i>   |  | 13b. COUNTY<br><i>Harford</i>   |  | 13c. CITY OR TOWN<br><i>Joppa</i>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Frank</i>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Margaret M. Holder</i>  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>   |  | 16b. SOCIAL SECURITY NO.<br><i>215-07-6286</i>  |  | 17. INFORMANT<br>ADDRESS<br><i>2417 Romney Rd. Joppa, Md.</i>   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>CARDIAC ARREST</i><br><i>4292</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><i>VIRAL PNEUMONIA</i>   |  |   |  |   |  |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |
| 22a. I certify that (if (this hospital) attended the deceased from <i>DEC 30</i> 19 <i>81</i> , to <i>Jan 5</i> 19 <i>82</i> , that (I) (we) last saw the deceased alive on <i>Jan 4</i> 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |  |
| 22b. SIGNATURE<br><i>Eric Steckler</i>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br><i>Jan 5, 1982</i>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>ERIC STECKLER</i>   |  |   |  | 22e. ADDRESS<br><i>Lutheran Hosp</i>  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>   |  | 23b. DATE<br><i>1-8-82</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Oak Lawn Cemetery</i>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Eastern Blvd. Balto. Co. Md.</i>               |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>C.S. Zeiler &amp; Son Inc. 6224 Eastern Avenue</i>   |  |   |  | 25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><i>JAN 7 1982 Thomas Jan Thibon</i>  |  |   |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

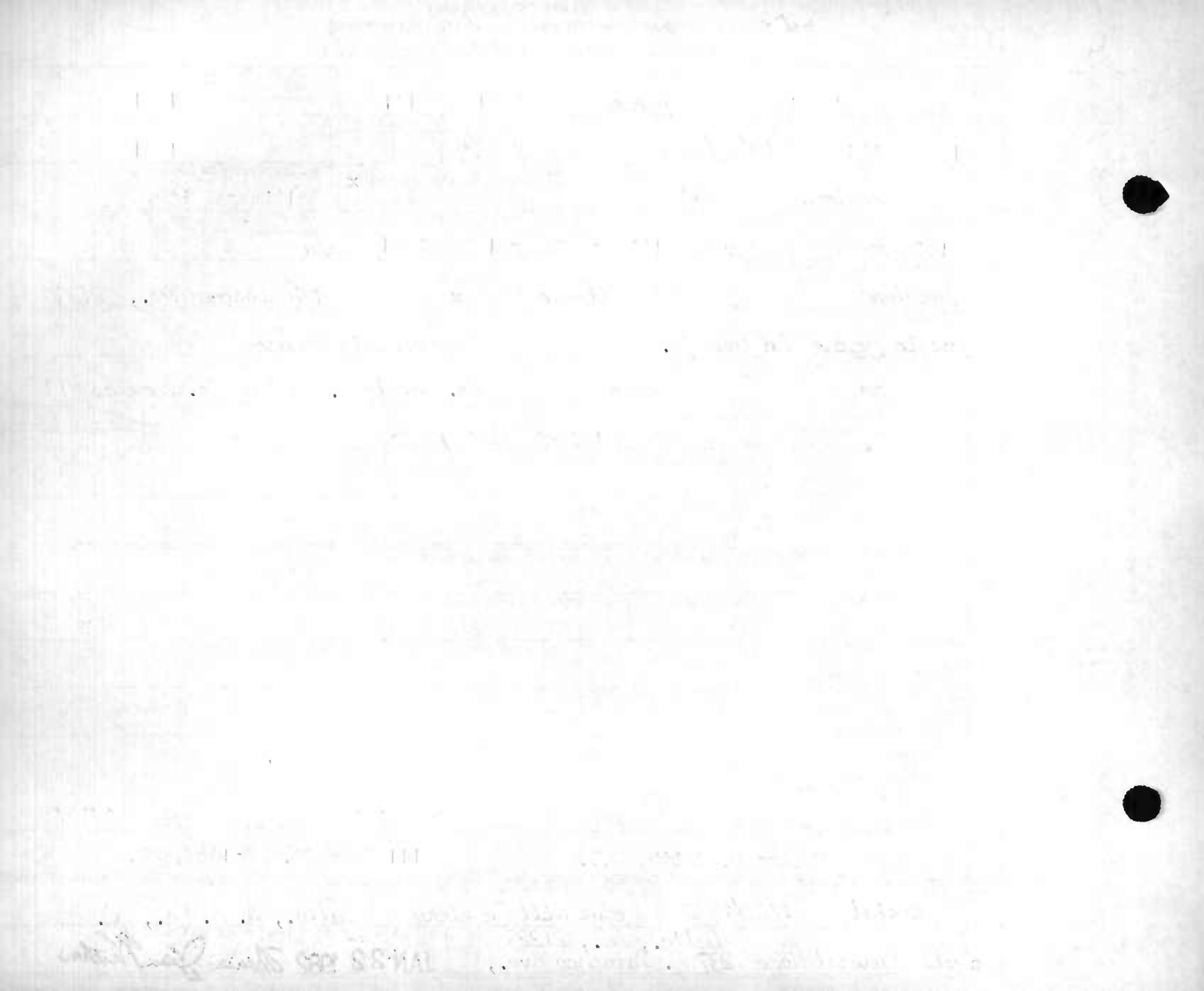
BP

DHMH-17  
(VR A15 ME (1))  
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |   |  |   |
|--|---|--|---|
| 1. FOR<br>STATE<br>REGISTRAR   |   | 2. 01256   |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |   | 2a. DATE KNOWN OF DEATH  |   |
| FIRST MIDDLE LAST<br>Jackie Eugene McClung, III  |   | MONTH DAY YEAR<br>1 18 1982  |   |
| 3. SEX   | 4. RACE   | 5. DATE OF BIRTH   | 6. AGE (IN YEARS)   |
| Male   | White   | 10/19/1981   | 2 29  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?                                | 8. MARRIED   | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |
| Maryland   | USA   | NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | Baltimore City, MD  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION    | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |
| Baltimore  | South Baltimore General Hospital                            | n/a  |   |
| 13a. STATE   | 13b. COUNTY   | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS?  |
| Maryland   |   | Baltimore  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME  | 15. MOTHER'S MAIDEN NAME                                    | 16. SOCIAL SECURITY NO.  |   |
| Jackie Eugene McClung Jr.  | Dawn Marie Sweeney  | none   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?   | 17. INFORMANT   | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |   |
| no   | Mr. Jackie E. McClung Jr. Same as #13                       | PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Sudden Infant Death Syndrome<br>7980<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>(c) _____ |   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |   |  |   |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           | 20. AUTOPSY?   |   |
|  |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  | 21b. TIME OF INJURY   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |   |
|  | HOUR A.M. MONTH DAY YEAR<br>P.M. 19                         |  |   |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION  |   |
|  |   | CITY OR TOWN COUNTY STATE  |   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |   |  |   |
| ACTUAL SIGNATURE   |   | TITLE (SPECIFY)  |   |
| Thomas D. Smith  |   | M.D. Deputy Chief  |   |
| EXAMINER'S NAME (TYPE OR PRINT)  |   | DATE SIGNED  |   |
| Thomas D. Smith, M.D.  |   | 1/19/82  |   |
| ADDRESS  |   | 111 Penn St. Balto., MD.   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  | 23b. DATE   | 23c. NAME OF CEMETERY OR CREMATORY   | 23d. LOCATION   |
| Burial   | 1/22/1982   | Cedar Hill Cemetery  | Balto., A. A. Co., Md.  |
| 24. FUNERAL DIRECTOR   | 25a. DATE REC'D. BY REGISTRAR                               |  | 25b. REGISTRAR'S SIGNATURE  |
| McCully Funeral Home   | JAN 22 1982   |  | Thomas D. Smith   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |   |  |
|---|--|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  |  | REG. NO.   |  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>James Joseph McCormick</b><br><b>Baby boy McCormick</b>  |  |  |  |  | 2a. DATE OF DEATH<br>MONTH <b>01</b> DAY <b>27</b> YEAR <b>82</b><br>2b. HOUR <b>9:19</b> AM |  |  |   |  |
| 3. SEX<br><b>male</b>   |  | 4. RACE<br><b>caucasian</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>01</b> DAY <b>14</b> YEAR <b>82</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>0</b> YRS  |  | 7. IF UNDER 1 YEAR<br>MONTHS <b>13</b> DAYS <b>13</b> HOURS <b>13</b> MIN   |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 9. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 11. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD  |  |   |  |
| 12. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore City Hospitals</b> |  |  |  | 14. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>none</b>   |  | 15. KIND OF BUSINESS OR INDUSTRY<br><b>—</b>  |  |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>CITY OR TOWN<br><b>Maryland Home</b>   |  | 17. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 18. STREET ADDRESS<br><b>7989 Nolpark Ct. 204</b>  |  |  |  |   |  |
| 19. FATHER'S NAME<br>FIRST <b>Brian</b> MIDDLE <b>McCormick</b> LAST <b>McCormick</b>   |  | 20. MOTHER'S MAIDEN NAME<br>FIRST <b>Catherine</b> MIDDLE <b>Creed</b> LAST <b>Creed</b>   |  | 21. ADDRESS<br><b>Glen Burnie<br/>Brian McCormick 7989 Nolpark Ct.</b>   |  |  |  |   |  |
| 22. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>N/A</b>   |  | 23. SOCIAL SECURITY NO.<br><b>N/A</b>  |  | 24. INFORMANT<br><b>Brian McCormick 7989 Nolpark Ct.</b>   |  |  |  |   |  |
| 25. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiac failure</b><br><b>7798</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>respiratory failure/pneumothorax</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) <b>prematurity</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |  |  |  |  |  |  |   |  |
| 26a. DATE OF OPERATION  |  | 26b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 27a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 27b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 28a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 28b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>  |  | 28c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |   |  |
| 29a. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 29b. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 29c. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |
| 30. I certify that (this hospital) attended the deceased from <b>Jan. 14, 1982</b> to <b>Jan. 27, 1982</b> , that (we) last saw the deceased alive on <b>1/27/82</b> 19 <b>82</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I (we) and/or) view the body after death.   |  |  |  |  |  |  |  |   |  |
| 31. SIGNATURE<br><b>[Signature]</b> MD  |  | DEGREE   |  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 32. DATE SIGNED<br><b>1/27/82</b>   |  |
| 33. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Harold P. Hudson M.D.</b>  |  | 34. ADDRESS<br><b>Baltimore City Hospitals</b>   |  |  |  |  |  |   |  |
| 35. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 36. DATE<br><b>1/30/82</b>   |  | 37. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery Brooklyn</b>   |  |  |  | 38. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>A.A. Md.</b>  |  |
| 39. FUNERAL DIRECTOR<br>NAME<br><b>George J. Gonce</b>  |  | 40. ADDRESS<br><b>4001 Ritchie Hwy</b>   |  | 41. DATE REC'D. BY REGISTRAR<br><b>FEB 1 1982</b>  |  | 42. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 8 2 0 1 2 5 8   |  |   |   |
|---|--|---|--|---|--|---|---|
| 1. FOR STATE REGISTRAR  |  |   |  | REG. NO.  |  |   |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ELIJAH</b>   |  |   |  | 2a. DATE OF DEATH<br>MONTH <b>1</b> DAY <b>9</b> YEAR <b>82</b>   |  |   |   |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>BLACK</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>9</b> DAY <b>9</b> YEAR <b>23</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>58</b>  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>S.C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE</b> MD.  |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BON SECOURS HOSP.</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Laborer</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |   |
| 13a. STATE<br><b>MD.</b>  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Balto</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                               |   |
| 14. FATHER'S NAME<br>FIRST <b>Kelly</b> MIDDLE <b>McCray</b> LAST <b>Binkey</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Clark</b> MIDDLE <b>Clark</b> LAST <b>Clark</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>  |  |   |   |
| 16b. SOCIAL SECURITY NO.<br><b>216 12 5925</b>  |  | 17. INFORMANT<br><b>Ruth McCray</b>   |  |   |  | ADDRESS<br><b>3907 Colbrone Rd.</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Coronary atherosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Coronary atherosclerosis</b>    |  |   |  |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |  |   |  |   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |   |
| 22b. SIGNATURE<br><b>Rotunda &amp; Sabun</b>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>1/11/82</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Rotunda &amp; Sabun</b>   |  |   |  | 22e. ADDRESS<br><b>Bon Secours Hospital</b>   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>1-15-82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem Pk.</b>  |  | 23d. LOCATION<br>CITY OR TOWN <b>Baltimore</b> COUNTY STATE <b>MD.</b>  |   |
| 24. FUNERAL DIRECTOR<br>NAME <b>Brown/Thompson F.H.</b> ADDRESS <b>1913 W. Baltimore St.</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>1/13/82</b> 25b. REGISTRAR'S SIGNATURE <b>Frances Van Thier</b>  |  |   |   |

1. The first part of the document is a letter from the President of the United States to the Congress, dated January 1, 1861. It is a very important document, as it sets out the policy of the new administration. The President states that he is committed to the principles of liberty and justice for all, and that he will work to maintain the Union and the Constitution.



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MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |   | 8 2 0 1 2 5 9   |   |
|---|--|---|---|---|---|
| 1. FOR STATE REGISTRAR  |  |   |   | REG. NO.  |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>WILLIAM B. MCCREADY</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JAN. 18, 1982</b>                               |   | 2b. HOUR<br>MIN.<br><b>1048 PM</b>                        |
| 3 SEX<br><b>Male</b>  | 4 RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 13 03</b>  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b>   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>YRS.</b>  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>North Carolina</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                       |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNIVERSITY OF MARYLAND</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Truck Mechanic</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Assoc. Trans.</b> |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>         | 13e. STREET ADDRESS<br><b>224 S. Calhoun Street 21223</b> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Burroughs McCready</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Addie Mae (Skkes)</b>                 |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>1923 to 1927 225-10-1200</b>   |   | 17. INFORMANT<br>ADDRESS <b>21223</b><br><b>Janet M. McCready 224 S. Calhoun Street</b>                 |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b><br><b>4100</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>pulmonary edema</b><br>(c) <b>recurrent MYOCARDIAL INFARCTIONS</b>               |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH              |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |   |   |   |   |
| 19a. DATE OF OPERATION<br><b>NOV. 1981</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>GROSS HEMATURIA</b>  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                               |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>NOT APPLICABLE</b> |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>JAN 6</b> , 19 <b>82</b> , to <b>JAN 18</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>JAN 18</b> , 19 <b>1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |   |   |
| 22b. SIGNATURE<br><b>Colleen D. Jude</b> MD   |  |   |   | 22c. DATE SIGNED<br><b>1/18/82</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Colleen D. Jude</b>   |  |   |   | 22e. ADDRESS<br><b>UNIVERSITY OF MARYLAND HOSPITAL</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>1/22/82</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven M. P.</b>   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Hubbard Funeral Home, Inc.</b>   |  | 24b. ADDRESS<br><b>4107 Wilkens Ave.</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 20 1982</b>   |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Theresa Jean Nathan</b>  |  |   |   |   |   |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 2 6 0

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |   |   |  |  |  |
|--|--|--|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Barbara A. McCreary</i>   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>1-3-82</i> |   |  | 2b. HOUR<br><i>9:35 PM</i>   |  |
| 3. SEX<br><i>Female</i>  |  | 4. RACE<br><i>Black</i>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>8 1 22</i>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>59</i> YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Md</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Balto</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Greater Penn. Ave. N.H</i> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |
| 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |   |   |  |  |  |
| 13a. STATE<br><i>Md</i>  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN<br><i>Balto.</i>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 13e. STREET ADDRESS<br><i>2458 Brentwood Ave.</i>  |  |  |   |   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Mal Ford</i>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Anna Mae Martin</i>  |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT ADDRESS<br><i>Anna Mae Parker 2206 Clifton Ave.</i>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cancer of Uterus</i><br>1790<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.                    |  |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (d)<br><i>old stroke</i>  |  |  |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>9-24</i> , 19 <i>81</i> , to <i>1-3</i> , 19 <i>82</i> , that (I) (we) last saw the deceased alive on <i>1-3</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. |  |  |   |   |  |  |  |
| 22b. SIGNATURE<br><i>Reginald O. Crosley</i>   |  | DEGREE   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                             |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Reginald O. Crosley</i>  |  | 22e. ADDRESS<br><i>1235 E. Monument St Balto Md</i>  |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>  |  | 23b. DATE<br><i>1/6/82</i>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Mt. Auburn Cem.</i>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Baltimore, Md.</i>  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>Wm C March F/H 1101 E. North Ave.</i>   |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><i>JAN 6 1982</i>  |  |  |  |
|  |  |  |   | 25b. REGISTRAR'S SIGNATURE<br><i>Thomas J. [Signature]</i>  |  |  |  |

MEDICAL CERTIFICATION

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NOTION NO. 2

114 - 21000

114 - 21000

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114 - 21000

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 2 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  | REG. NO. 2 0 1 2 6 1  |  |
|---|--|--|--|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  |  |  |  |  |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Lord Curtis McDaniel  |  |  |  |  |  |  |  |  |  | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br>1 29 1982 |  |
| 3. SEX<br>Male  |  | 4. RACE<br>Negro   |  | 5. DATE OF BIRTH (MONTH DAY YEAR)<br>Oct. 7 1961   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>20 YRS.   |  | IF UNDER 1 YR. MONTHS DAYS HOURS MIN.  |  | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR<br>1 29 1982  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>So. Carolina   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                                  |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>2828 Ellicott Drive |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Orderly                     |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Springfield   |  |   |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>2828 Ellicott Drive 21216   |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>L. C. McDaniel   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Geraldine Neely  |  |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br>NO  |  | (IF YES, GIVE WAR OR DATES)  |  | 16b. SOCIAL SECURITY NO.<br>216-76-1667  |  | 17. INFORMANT<br>Geraldine McDaniel/2828 Ellicott  |  | ADDRESS Drive  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Hanging</u><br>9530<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |  |  |  |  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                     |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>? P.M. 1 29 1982   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>subject hanged self |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>home  |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br>2828 Ellicott Dr. Balto. Md.                       |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |  |  |  |  |  |  |  |  |   |  |
| ACTUAL SIGNATURE<br><i>Thomas D. Smith</i>  |  |  |  | TITLE (SPECIFY)<br>Deputy Chief  |  |  |  | DATE SIGNED<br>1/30/82   |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Thomas D. Smith, M.D.  |  |  |  | ADDRESS<br>111 Penn St. Balto., MD.  |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>02/04/82  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>ARBUTUS MEMORIAL PK  |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>ARBUTUS BALTO MARYLAND                                    |  |   |  |
| 24. FUNERAL DIRECTOR<br>MARSHALL W JONES, JR./4101 EDMONDSON AVE  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 5 1982  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Van Natten</i>  |  |   |  |

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Theodore R. McDonald

REG. NO.

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|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>Theodore ROBERT McDonald</b>  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>1 29 82</b>   |  | 2b. HOUR <b>9A</b> M  |  |
| 3. SEX <b>MALE</b>  |  | 4. RACE <b>Caucasian</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>6 4 05</b>   |  |
| 6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.  |  | 7. IF UNDER 1 YEAR MONTHS DAYS  |  | 8. IF UNDER 24 HRS. HOURS MIN.  |  |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>   |  | 9b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.  |  |
| 10. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Deaton Medical Center</b>   |  | 11a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Truck Driver</b>   |  | 11b. KIND OF BUSINESS OR INDUSTRY <b>Kramer Bros.</b>   |  |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12a. STATE <b>Md.</b> 12b. COUNTY <b>A.A.</b> 12c. CITY OR TOWN <b>Glen Burnie</b> |  | 13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13b. STREET ADDRESS <b>Apt 32 8039 Greenleaf Terrace</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>unk.</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>unk.</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>   |  |
| 16b. SOCIAL SECURITY NO. <b>217 01 7699</b>   |  | 17. INFORMANT ADDRESS <b>Barbara Fones same as 13 e</b>   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ARRHYTHMIA</b><br><b>4292</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) <b>-</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |
| 19a. DATE OF OPERATION <b>?</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>BENIGN PROSTATIC HYPERTROPHY</b>  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  | 22a. I certify that (I) <b>this hospital</b> attended the deceased from <b>1/4 19 82</b> to <b>1/29 19 82</b> , that (I) <b>(we)</b> lost saw the deceased alive on <b>1/28 19 82</b> , and that in <b>(my)</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>(I/we)</b> <b>(did)</b> (did not) view the body after death. |  | 22b. SIGNATURE <b>Donald R. Lurye, MD</b> DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>   |  |
| 22c. DATE SIGNED <b>1/29/82</b>   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DONALD R. LURYE, MD</b>  |  | 22e. ADDRESS <b>J.L. DEATON MED. CTR., 611 SO. CHARLES ST., BALTO., MD</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  | 23b. DATE <b>2/1/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cem</b>   |  |
| 23d. LOCATION CITY OR TOWN <b>Baltimore, Maryland</b>   |  | 24. FUNERAL DIRECTOR NAME <b>George J. Gonce</b> ADDRESS <b>4001 Ritchie Hwy</b>  |  | 25a. DATE RECEIVED BY REGISTRAR <b>FEB 1 1982</b> 25b. REGISTRAR'S SIGNATURE <b>Theresa</b>   |  |

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DEPARTMENT OF JUSTICE  
WASHINGTON, D.C.

OFFICE OF THE ATTORNEY GENERAL  
WASHINGTON, D.C.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or page.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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| FOR<br>1. STATE<br>REGISTRAR   |  | REG. NO.   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>VERONICA F. McDONALD<br>Veronica F. McDonald   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>1/7/82<br>8:25 AM  |  |
| 3. SEX<br>Female   | 4. RACE<br>Caucasian   | 5. DATE OF BIRTH MONTH DAY YEAR<br>03 25 01  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>80 YRS  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore city MD  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Mercy Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Payroll Clerk   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Balto. Transit Co.  |
| 13a. STATE<br>MD.  | 13b. COUNTY<br>Balt.   | 13c. CITY OR TOWN<br>Baltimore   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>William T McDonald  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Catherine McHale   | 13e. STREET ADDRESS<br>2735 Chesterfield Ave.  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>no  | 16b. SOCIAL SECURITY NO.<br>220-07-0164  | 17. INFORMANT<br>Helen McDonald (sister)   | ADDRESS<br>same address  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u><br>7301<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Sepsis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Chronic Osteomyelitis left hip</u>                     |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><u>Multiple decubitus ulcers.</u>  |  |  |  |
| 19a. DATE OF OPERATION<br>12/23/81   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Removal of Zickle nail   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/12/81, 19 81, to 1/7, 19 82, that (I) (we) last saw the deceased alive on 1/7, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |
| 22b. SIGNATURE<br>Frederick T Lohr MD.   |  | 22c. DATE SIGNED<br>1/7/82   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Frederick T Lohr  |  | 22e. ADDRESS<br>Univ of Md Hospital.   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  | 23b. DATE<br>1/9/82  | 23c. NAME OF CEMETERY OR CREMATORY<br>New Cathedral  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Balto. MD.  |
| 24. FUNERAL DIRECTOR<br>Schimunek Funeral Home, Inc.<br>3331 Brehms Lane, Balto. Md. 21213   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 12 1982   | 25b. REGISTRAR'S SIGNATURE<br>James J. [Signature]   |



January 1965

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Released on Approval By Dr Redner/Per Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Thereafter, the registrars should remove the top of page 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury (or other traumatic event), the medical examiner must be notified.

Item 8 8564 2/17/82 gj

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 2 6 4

REG. NO.

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|--|--|--|--|---|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST<br>Richard   |  | MIDDLE<br>Mc  |  | LAST<br>Duffie  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>Jan 19, 1982                                     |  |  |  | 2b. HOUR<br>2:01p <sub>M</sub>               |  |
| 3. SEX<br>male   |  | 4. RACE<br>Negro   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>2-27 31  |  |   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>50 YRS  |  |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                           |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN BALTIMORE CITY, GIVE STREET ADDRESS)<br>Johns Hopkins Hospital |  |   |  |   |  | 12a. USUAL OCCUPATION<br>(GIVE WORK OR NAME OF BUSINESS)<br>Paint Factory            |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY            |  |
| 13a. STATE<br>Md.  |  | 13b. COUNTY<br>-   |  | 13c. CITY OR TOWN<br>Balto.   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>927 N. Chapel Street  |  |  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Richard   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Mary Valentine   |  |   |  |   |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>-   |  | 17. INFORMANT ADDRESS<br>Hilda McDuffie 927 N. Chapel St.   |  |   |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>laryngeal cancer</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. |  |  |  |   |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |  |  |  |   |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18b. PART I OR PART 2)                 |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>Johns Hopkins Hospital                     |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/19/82</u> 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) and (you) must view the body after death.   |  |  |  |   |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><u>Robert L. Redner</u> MD   |  |  |  | DEGREE  |  |   |  | 22c. DATE SIGNED<br>1/19/82  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Robert L. Redner MD   |  |  |  | 22e. ADDRESS<br>Johns Hopkins Hosp.   |  |   |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(CHECK)<br>Burial   |  |  |  | 23b. DATE<br>1-23-82  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore Cem.  |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. Baltimore City MD.  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Calvin B. Scruggs  |  |  |  | ADDRESS<br>1412 E. Preston St.  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 21 1982   |  |  |  |  |  |

MEDICAL CERTIFICATION

1917

NOTED



Handwritten notes and signatures, including a large 'X' mark.

Handwritten notes and signatures, including a large 'X' mark.

Handwritten notes and signatures, including a large 'X' mark.

Handwritten notes and signatures, including a large 'X' mark.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8 2 0 1 2 6 5   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1- FOR STATE REGISTRAR   |  |   |  | REG. NO.  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Margaret A. McEntee</b>  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>1 15 82</b>  |  | 2b. HOUR<br><b>8:37 PM</b>  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>12 24 12</b>  |  | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>69 YRS.</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New Jersey</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore, Md.</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Agnes Hospital</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><b>MD.</b>   |  | 13b. COUNTY<br><b>BALTO.</b>  |  | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 13d. STREET ADDRESS<br><b>207 Mallow Hill Road</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Richard</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Margaret Lyons</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.<br><b>215-408-871</b>  |  | 17. INFORMANT ADDRESS (Daughter)<br><b>Margaret McEntee-207 Mallow Hill Rd</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>MYO CARDIAC ARREST</b><br><b>4100</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>MYO CARDIAC INFARCTION</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1. 15</b> , 19 <b>82</b> , to <b>1. 15</b> , 19 <b>82</b> , that (we) lost above, the deceased alive on <b>1. 15. 82</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.           |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Reetha Raja MD</b>  |  |   |  | DEGREE <b>RESIDENT</b><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  | 22c. DATE SIGNED<br><b>1/15/82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>REETHA RAJA</b>  |  |   |  | 22e. ADDRESS<br><b>ST. AGNES HOSPITAL, BALT, MD-21229</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>Jan 19-1982</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Balto Nail Cms</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Balto Md</b>  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Fairley Funeral Home</b>   |  |   |  | ADDRESS<br><b>Catonville Md</b>   |  | 25a. DATE RECEIVED BY REGISTRAR<br><b>JAN 20 1982</b>   |  |
|  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Thom J. [Signature]</b>  |  |   |  |

12 MO 00 360



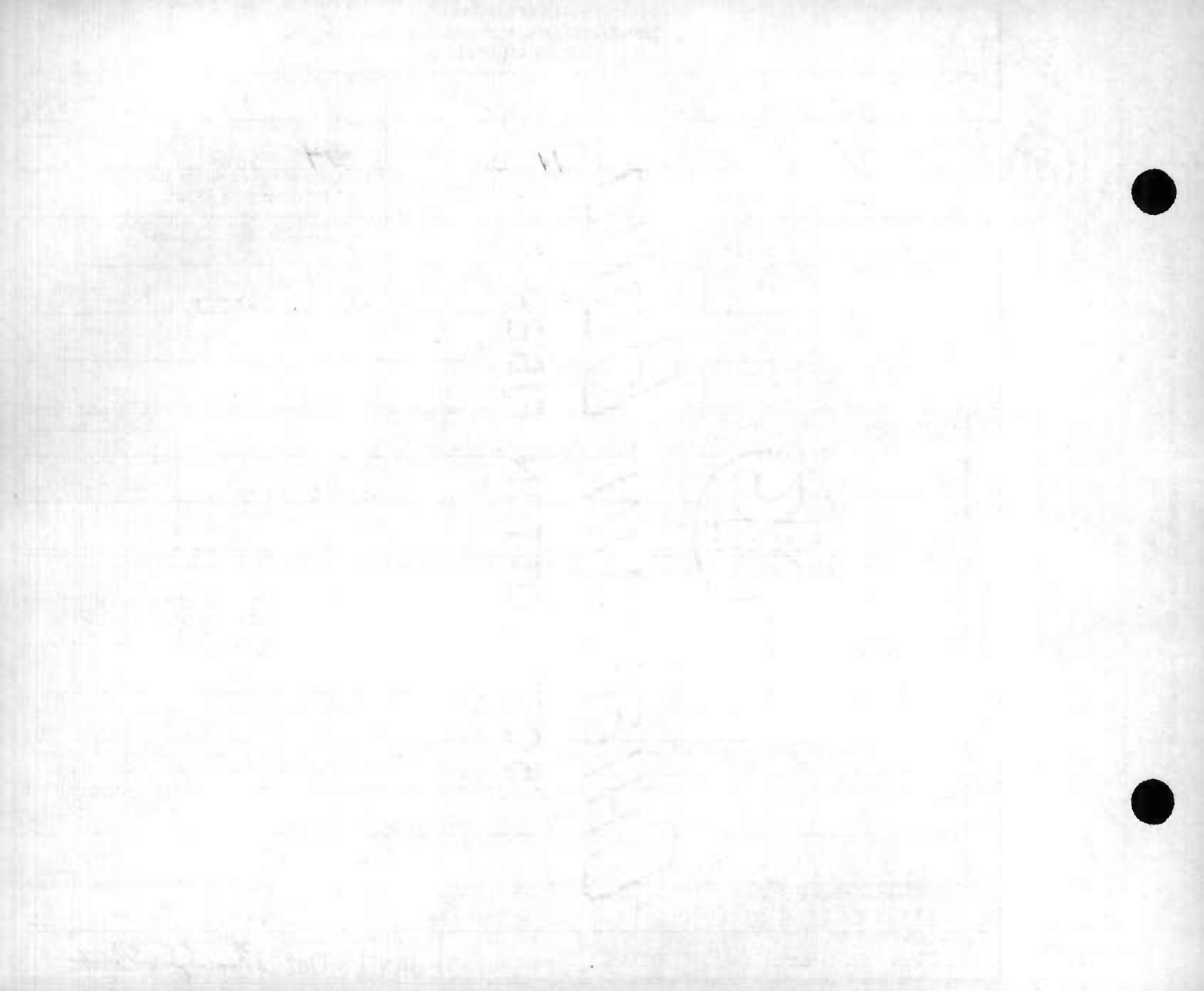


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 301-338-1300.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |   |  |  |   |  |
|--|--|--|--|--|---|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  |  |   |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>BESSIE V. MCHEURY  |  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR<br>1 13 82 700 PM |  |  |   |  |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>BLACK   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>11 01 27  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>54 YRS.   |  | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Va  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore city MD.                                   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore City Hospital                    |  |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br>Md   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>219 N. Patterson Park Ave  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Solomon Simmons   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Gladys   |   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  |  |  | 16b. SOCIAL SECURITY NO.<br>213-28-7752  |   | 17. INFORMANT ADDRESS<br>Vanessa Walker 423 N. Bradford St                                   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u><br>1629<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic adenocarcinoma of the lung</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>7/80 original diagnosis |  |  |  |  |   |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |   |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>80</u> , to <u>Jan 13</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>Jan 13</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |   |  |  |   |  |
| 22b. SIGNATURE<br>Lori D Karan MD  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |   | 22c. DATE SIGNED<br>Jan 31 1982  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>LORI D KARAN MD   |  | 22e. ADDRESS<br>BALTIMORE CITY HOSPITAL  |  |  |   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>1/18/82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview Mem Pk  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Catonsville Md                                    |  |   |  |
| 24. FUNERAL DIRECTOR<br>William C. March F/H 1101 E. North Ave   |  |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br>JAN 18 1982                      |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other illuminating event, the funeral director must not put it on page 4.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 2 0 1 2 6 7   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Erwin N. McLyman</b>   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 31 82</b>   |  | 2b. HOUR<br><b>7:20 A.M.</b>   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 6 1906</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS.  |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>       |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore City Hospital</b> |  | 12a. OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Mechanic</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Beth. Steel</b>  |  |
| 13a. STATE<br><b>Maryland</b>   |  |   |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Dundalk</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William McLyman</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elizabeth Smith</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>213-07-6987</b>  |  | 17. INFORMANT<br><b>Juanita L. McLyman</b>  |  | ADDRESS <b>533 Westfield Rd. Balto., MD. 21222</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>cardiogenic shock</b><br><b>7855</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>11 24</b> 19 <b>82</b> , to <b>1/31</b> 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                         |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Lloyd Stale</b>  |  |   |  | DEGREE<br><b>MD</b><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Lloyd Stale</b>   |  |   |  | 22e. ADDRESS<br><b>Balt City Hospital</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>2/3/1982</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>First United Evang.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Duda-Ruck, Inc. 7922 Wise Avenue Dundalk, MD. 21222</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 3 1982</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>James J. Martin</b>   |  |

RECEIVED  
JUL 1952

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 2 6 8

REG. NO.

|  |  |  |   |   |  |  |  |
|--|--|--|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Amy Lynn McNeal</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1-25-82</b> |   | 2b. HOUR<br><b>5<sup>11</sup> P.M.</b> |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 24 81</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><b>6 6</b>  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALT. CITY</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Never Employed</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>N/A</b>  |  |
| 13a. STATE<br><b>MARYLAND</b>  |  |  |   | 13b. COUNTY<br><b>BALTIMORE</b>   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George McNeal, Sr.</b>  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Linda Crowley</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>N/A</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>George McNeal 19 S. Chapel Street 21231</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b><br><b>7707</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>SEVERE BRONCHOPULMONARY DYSPLASIA</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) <b>PREMATURE BIRTH</b> |  |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 h</b><br><b>6 m</b><br><b>6 m</b>                                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>ARTHROGRYPOSIIS MULTIPLEX CONGENITA</b>   |  |  |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (in) this hospital attended the deceased from <b>8-2</b> , 19 <b>81</b> , to <b>1-25</b> , 19 <b>82</b> , that (in) (we) last saw the deceased live on <b>1-25</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.                           |  |  |   |   |  |  |  |
| 22b. SIGNATURE<br><b>David Marc Virshup MD</b>   |  |  |   | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>1-25-82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DAVID VIRSHUP MD</b>   |  |  |   | 22e. ADDRESS<br><b>3755 BEECH AV, BALTIMORE</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>   |  | 23b. DATE<br><b>1-28-82</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. A. Fialkowski 2007-09 Eastern Avenue</b>  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 27 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>James J. Nathan</b>   |  |

1952

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

Item 14 G 564 2/19/82 GAB

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 2 6 9

REG. NO.

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 2a. DATE OF DEATH   |  | MONTH DAY YEAR   |  | 2b. HOUR   |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST MIDDLE LAST   |  | JANUARY 24, 1982   |  | 2:00pm   |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                |  |
| Female   |  | Black   |  | 8 MONTH 13 Y 23 AR   |  | 58   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |  |
| N.C.   |  | USA   |  |  |  | Baltimore City   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| Baltimore  |  | Church Home   |  |  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  | 13b. COUNTY   |  | 13c. INSIDE CITY LIMITS?   |  | 13d. STREET ADDRESS  |  |
| MD   |  | Baltimore   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 2642 E. Oliver St.   |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.                                       |  |
| George H. Williams   |  | Amy Davis   |  | No   |  | N/A  |  |
| 17. INFORMANT  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  | 19. DATE OF OPERATION  |  | 20a. AUTOPSY?  |  |
| Ernest McNeil  |  | PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ADENOCARCINOMA WITH METASTASIS</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>SEIZURE DISORDER</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____ |  | 1991   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
| 2642 E. Oliver St.   |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)       |  | 21b. TIME OF INJURY  |  |
|  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  | 21d. INJURY OCCURRED   |  |
|  |  |   |  |  |  | 21e. PLACE OF INJURY   |  |
|  |  |   |  |  |  | 21f. LOCATION  |  |
|  |  |   |  |  |  | 21g. DATE SIGNED   |  |
|  |  |   |  |  |  | 21h. SIGNATURE   |  |
|  |  |   |  |  |  | 21i. PHYSICIAN'S NAME  |  |
|  |  |   |  |  |  | 21j. ADDRESS   |  |
|  |  |   |  |  |  | 21k. DATE SIGNED   |  |
|  |  |   |  |  |  | 21l. SIGNATURE   |  |
|  |  |   |  |  |  | 21m. PHYSICIAN'S NAME  |  |
|  |  |   |  |  |  | 21n. ADDRESS   |  |
|  |  |   |  |  |  | 21o. DATE SIGNED   |  |
|  |  |   |  |  |  | 21p. SIGNATURE   |  |
|  |  |   |  |  |  | 21q. PHYSICIAN'S NAME  |  |
|  |  |   |  |  |  | 21r. ADDRESS   |  |
|  |  |   |  |  |  | 21s. DATE SIGNED   |  |
|  |  |   |  |  |  | 21t. SIGNATURE   |  |
|  |  |   |  |  |  | 21u. PHYSICIAN'S NAME  |  |
|  |  |   |  |  |  | 21v. ADDRESS   |  |
|  |  |   |  |  |  | 21w. DATE SIGNED   |  |
|  |  |   |  |  |  | 21x. SIGNATURE   |  |
|  |  |   |  |  |  | 21y. PHYSICIAN'S NAME  |  |
|  |  |   |  |  |  | 21z. ADDRESS   |  |
|  |  |   |  |  |  | 21aa. DATE SIGNED  |  |
|  |  |   |  |  |  | 21ab. SIGNATURE  |  |
|  |  |   |  |  |  | 21ac. PHYSICIAN'S NAME   |  |
|  |  |   |  |  |  | 21ad. ADDRESS  |  |
|  |  |   |  |  |  | 21ae. DATE SIGNED  |  |
|  |  |   |  |  |  | 21af. SIGNATURE  |  |
|  |  |   |  |  |  | 21ag. PHYSICIAN'S NAME   |  |
|  |  |   |  |  |  | 21ah. ADDRESS  |  |
|  |  |   |  |  |  | 21ai. DATE SIGNED  |  |
|  |  |   |  |  |  | 21aj. SIGNATURE  |  |
|  |  |   |  |  |  | 21ak. PHYSICIAN'S NAME   |  |
|  |  |   |  |  |  | 21al. ADDRESS  |  |
|  |  |   |  |  |  | 21am. DATE SIGNED  |  |
|  |  |   |  |  |  | 21an. SIGNATURE  |  |
|  |  |   |  |  |  | 21ao. PHYSICIAN'S NAME   |  |
|  |  |   |  |  |  | 21ap. ADDRESS  |  |
|  |  |   |  |  |  | 21aq. DATE SIGNED  |  |
|  |  |   |  |  |  | 21ar. SIGNATURE  |  |
|  |  |   |  |  |  | 21as. PHYSICIAN'S NAME   |  |
|  |  |   |  |  |  | 21at. ADDRESS  |  |
|  |  |   |  |  |  | 21au. DATE SIGNED  |  |
|  |  |   |  |  |  | 21av. SIGNATURE  |  |
|  |  |   |  |  |  | 21aw. PHYSICIAN'S NAME   |  |
|  |  |   |  |  |  | 21ax. ADDRESS  |  |
|  |  |   |  |  |  | 21ay. DATE SIGNED  |  |
|  |  |   |  |  |  | 21az. SIGNATURE  |  |
|  |  |   |  |  |  | 21ba. PHYSICIAN'S NAME   |  |
|  |  |   |  |  |  | 21bb. ADDRESS  |  |
|  |  |   |  |  |  | 21bc. DATE SIGNED  |  |
|  |  |   |  |  |  | 21bd. SIGNATURE  |  |
|  |  |   |  |  |  | 21be. PHYSICIAN'S NAME   |  |
|  |  |   |  |  |  | 21bf. ADDRESS  |  |
|  |  |   |  |  |  | 21bg. DATE SIGNED  |  |
|  |  |   |  |  |  | 21bh. SIGNATURE  |  |
|  |  |   |  |  |  | 21bi. PHYSICIAN'S NAME   |  |
|  |  |   |  |  |  | 21bj. ADDRESS  |  |
|  |  |   |  |  |  | 21bk. DATE SIGNED  |  |
|  |  |   |  |  |  | 21bl. SIGNATURE  |  |
|  |  |   |  |  |  | 21bm. PHYSICIAN'S NAME   |  |
|  |  |   |  |  |  | 21bn. ADDRESS  |  |
|  |  |   |  |  |  | 21bo. DATE SIGNED  |  |
|  |  |   |  |  |  | 21bp. SIGNATURE  |  |
|  |  |   |  |  |  | 21bq. PHYSICIAN'S NAME   |  |
|  |  |   |  |  |  | 21br. ADDRESS  |  |
|  |  |   |  |  |  | 21bs. DATE SIGNED  |  |
|  |  |   |  |  |  | 21bt. SIGNATURE  |  |
|  |  |   |  |  |  | 21bu. PHYSICIAN'S NAME   |  |
|  |  |   |  |  |  | 21bv. ADDRESS  |  |
|  |  |   |  |  |  | 21bw. DATE SIGNED  |  |
|  |  |   |  |  |  | 21bx. SIGNATURE  |  |
|  |  |   |  |  |  | 21by. PHYSICIAN'S NAME   |  |
|  |  |   |  |  |  | 21bz. ADDRESS  |  |
|  |  |   |  |  |  | 21ca. DATE SIGNED  |  |
|  |  |   |  |  |  | 21cb. SIGNATURE  |  |
|  |  |   |  |  |  | 21cc. PHYSICIAN'S NAME   |  |
|  |  |   |  |  |  | 21cd. ADDRESS  |  |
|  |  |   |  |  |  | 21ce. DATE SIGNED  |  |
|  |  |   |  |  |  | 21cf. SIGNATURE  |  |
|  |  |   |  |  |  | 21cg. PHYSICIAN'S NAME   |  |
|  |  |   |  |  |  | 21ch. ADDRESS  |  |
|  |  |   |  |  |  | 21ci. DATE SIGNED  |  |
|  |  |   |  |  |  | 21cj. SIGNATURE  |  |
|  |  |   |  |  |  | 21ck. PHYSICIAN'S NAME   |  |
|  |  |   |  |  |  | 21cl. ADDRESS  |  |
|  |  |   |  |  |  | 21cm. DATE SIGNED  |  |
|  |  |   |  |  |  | 21cn. SIGNATURE  |  |
|  |  |   |  |  |  | 21co. PHYSICIAN'S NAME   |  |
|  |  |   |  |  |  | 21cp. ADDRESS  |  |
|  |  |   |  |  |  | 21cq. DATE SIGNED  |  |
|  |  |   |  |  |  | 21cr. SIGNATURE  |  |
|  |  |   |  |  |  | 21cs. PHYSICIAN'S NAME   |  |
|  |  |   |  |  |  | 21ct. ADDRESS  |  |
|  |  |   |  |  |  | 21cu. DATE SIGNED  |  |
|  |  |   |  |  |  | 21cv. SIGNATURE  |  |
|  |  |   |  |  |  | 21cw. PHYSICIAN'S NAME   |  |
|  |  |   |  |  |  | 21cx. ADDRESS  |  |
|  |  |   |  |  |  | 21cy. DATE SIGNED  |  |
|  |  |   |  |  |  | 21cz. SIGNATURE  |  |
|  |  |   |  |  |  | 21da. PHYSICIAN'S NAME   |  |
|  |  |   |  |  |  | 21db. ADDRESS  |  |
|  |  |   |  |  |  | 21dc. DATE SIGNED  |  |
|  |  |   |  |  |  | 21dd. SIGNATURE  |  |
|  |  |   |  |  |  | 21de. PHYSICIAN'S NAME   |  |
|  |  |   |  |  |  | 21df. ADDRESS  |  |
|  |  |   |  |  |  | 21dg. DATE SIGNED  |  |
|  |  |   |  |  |  | 21dh. SIGNATURE  |  |
|  |  |   |  |  |  | 21di. PHYSICIAN'S NAME   |  |
|  |  |   |  |  |  | 21dj. ADDRESS  |  |
|  |  |   |  |  |  | 21dk. DATE SIGNED  |  |
|  |  |   |  |  |  | 21dl. SIGNATURE  |  |
|  |  |   |  |  |  | 21dm. PHYSICIAN'S NAME   |  |
|  |  |   |  |  |  | 21dn. ADDRESS  |  |
|  |  |   |  |  |  | 21do. DATE SIGNED  |  |
|  |  |   |  |  |  | 21dp. SIGNATURE  |  |
|  |  |   |  |  |  | 21dq. PHYSICIAN'S NAME   |  |
|  |  |   |  |  |  | 21dr. ADDRESS  |  |
|  |  |   |  |  |  | 21ds. DATE SIGNED  |  |
|  |  |   |  |  |  | 21dt. SIGNATURE  |  |
|  |  |   |  |  |  | 21du. PHYSICIAN'S NAME   |  |
|  |  |   |  |  |  | 21dv. ADDRESS  |  |
|  |  |   |  |  |  | 21dw. DATE SIGNED  |  |
|  |  |   |  |  |  | 21dx. SIGNATURE  |  |
|  |  |   |  |  |  | 21dy. PHYSICIAN'S NAME   |  |
|  |  |   |  |  |  | 21dz. ADDRESS  |  |
|  |  |   |  |  |  | 21ea. DATE SIGNED  |  |
|  |  |   |  |  |  | 21eb. SIGNATURE  |  |
|  |  |   |  |  |  | 21ec. PHYSICIAN'S NAME   |  |
|  |  |   |  |  |  | 21ed. ADDRESS  |  |
|  |  |   |  |  |  | 21ee. DATE SIGNED  |  |
|  |  |   |  |  |  | 21ef. SIGNATURE  |  |
|  |  |   |  |  |  | 21eg. PHYSICIAN'S NAME   |  |
|  |  |   |  |  |  | 21eh. ADDRESS  |  |
|  |  |   |  |  |  | 21ei. DATE SIGNED  |  |
|  |  |   |  |  |  | 21ej. SIGNATURE  |  |
|  |  |   |  |  |  | 21ek. PHYSICIAN'S NAME   |  |
|  |  |   |  |  |  | 21el. ADDRESS  |  |
|  |  |   |  |  |  | 21em. DATE SIGNED  |  |
|  |  |   |  |  |  | 21en. SIGNATURE  |  |
|  |  |   |  |  |  | 21eo. PHYSICIAN'S NAME   |  |
|  |  |   |  |  |  | 21ep. ADDRESS  |  |
|  |  |   |  |  |  | 21eq. DATE SIGNED  |  |
|  |  |   |  |  |  | 21er. SIGNATURE  |  |
|  |  |   |  |  |  | 21es. PHYSICIAN'S NAME   |  |
|  |  |   |  |  |  | 21et. ADDRESS  |  |
|  |  |   |  |  |  | 21eu. DATE SIGNED  |  |
|  |  |   |  |  |  | 21ev. SIGNATURE  |  |
|  |  |   |  |  |  | 21ew. PHYSICIAN'S NAME   |  |
|  |  |   |  |  |  | 21ex. ADDRESS  |  |
|  |  |   |  |  |  | 21ey. DATE SIGNED  |  |
|  |  |   |  |  |  | 21ez. SIGNATURE  |  |
|  |  |   |  |  |  | 21fa. PHYSICIAN'S NAME   |  |
|  |  |   |  |  |  | 21fb. ADDRESS  |  |
|  |  |   |  |  |  | 21fc. DATE SIGNED  |  |
|  |  |   |  |  |  | 21fd. SIGNATURE  |  |
|  |  |   |  |  |  | 21fe. PHYSICIAN'S NAME   |  |
|  |  |   |  |  |  | 21ff. ADDRESS  |  |
|  |  |   |  |  |  | 21fg. DATE SIGNED  |  |
|  |  |   |  |  |  | 21fh. SIGNATURE  |  |
|  |  |   |  |  |  | 21fi. PHYSICIAN'S NAME   |  |
|  |  |   |  |  |  | 21fj. ADDRESS  |  |
|  |  |   |  |  |  | 21fk. DATE SIGNED  |  |
|  |  |   |  |  |  | 21fl. SIGNATURE  |  |
|  |  |   |  |  |  | 21fm. PHYSICIAN'S NAME   |  |
|  |  |   |  |  |  | 21fn. ADDRESS  |  |
|  |  |   |  |  |  | 21fo. DATE SIGNED  |  |
|  |  |   |  |  |  | 21fp. SIGNATURE  |  |
|  |  |   |  |  |  | 21fq. PHYSICIAN'S NAME   |  |
|  |  |   |  |  |  | 21fr. ADDRESS  |  |
|  |  |   |  |  |  | 21fs. DATE SIGNED  |  |
|  |  |   |  |  |  | 21ft. SIGNATURE  |  |
|  |  |   |  |  |  | 21fu. PHYSICIAN'S NAME   |  |
|  |  |   |  |  |  | 21fv. ADDRESS  |  |
|  |  |   |  |  |  | 21fw. DATE SIGNED  |  |
|  |  |   |  |  |  | 21fx. SIGNATURE  |  |
|  |  |   |  |  |  | 21fy. PHYSICIAN'S NAME   |  |
|  |  |   |  |  |  | 21fz. ADDRESS  |  |
|  |  |   |  |  |  | 21ga. DATE SIGNED  |  |
|  |  |   |  |  |  | 21gb. SIGNATURE  |  |
|  |  |   |  |  |  | 21gc. PHYSICIAN'S NAME   |  |
|  |  |   |  |  |  | 21gd. ADDRESS  |  |
|  |  |   |  |  |  | 21ge. DATE SIGNED  |  |
|  |  |   |  |  |  | 21gf. SIGNATURE  |  |
|  |  |   |  |  |  | 21gg. PHYSICIAN'S NAME   |  |
|  |  |   |  |  |  | 21gh. ADDRESS  |  |
|  |  |   |  |  |  | 21gi. DATE SIGNED  |  |
|  |  |   |  |  |  | 21gj. SIGNATURE  |  |
|  |  |   |  |  |  | 21gk. PHYSICIAN'S NAME   |  |
|  |  |   |  |  |  | 21gl. ADDRESS  |  |
|  |  |   |  |  |  | 21gm. DATE SIGNED  |  |
|  |  |   |  |  |  | 21gn. SIGNATURE  |  |
|  |  |   |  |  |  | 21go. PHYSICIAN'S NAME   |  |
|  |  |   |  |  |  | 21gp. ADDRESS  |  |
|  |  |   |  |  |  | 21gq. DATE SIGNED  |  |
|  |  |   |  |  |  | 21gr. SIGNATURE  |  |
|  |  |   |  |  |  | 21gs. PHYSICIAN'S NAME   |  |
|  |  |   |  |  |  | 21gt. ADDRESS  |  |
|  |  |   |  |  |  | 21gu. DATE SIGNED  |  |
|  |  |   |  |  |  | 21gv. SIGNATURE  |  |
|  |  |   |  |  |  | 21gw. PHYSICIAN'S NAME   |  |
|  |  |   |  |  |  | 21gx. ADDRESS  |  |
|  |  |   |  |  |  | 21gy. DATE SIGNED  |  |
|  |  |   |  |  |  | 21gz. SIGNATURE  |  |
|  |  |   |  |  |  | 21ha. PHYSICIAN'S NAME   |  |
|  |  |   |  |  |  | 21hb. ADDRESS  |  |
|  |  |   |  |  |  | 21hc. DATE SIGNED  |  |
|  |  |   |  |  |  | 21hd. SIGNATURE  |  |
|  |  |   |  |  |  | 21he. PHYSICIAN'S NAME   |  |
|  |  |   |  |  |  | 21hf. ADDRESS  |  |
|  |  |   |  |  |  | 21hg. DATE SIGNED  |  |
|  |  |   |  |  |  | 21hh. SIGNATURE  |  |
|  |  |   |  |  |  | 21hi. PHYSICIAN'S NAME   |  |
|  |  |   |  |  |  | 21hj. ADDRESS  |  |
|  |  |   |  |  |  | 21hk. DATE SIGNED  |  |
|  |  |   |  |  |  | 21hl. SIGNATURE  |  |
|  |  |   |  |  |  | 21hm. PHYSICIAN'S NAME   |  |
|  |  |   |  |  |  | 21hn. ADDRESS  |  |
|  |  |   |  |  |  | 21ho. DATE SIGNED  |  |
|  |  |   |  |  |  | 21hp. SIGNATURE  |  |
|  |  |   |  |  |  | 21hq. PHYSICIAN'S NAME   |  |
|  |  |   |  |  |  | 21hr. ADDRESS  |  |
|  |  |   |  |  |  | 21hs. DATE SIGNED  |  |
|  |  |   |  |  |  | 21ht. SIGNATURE  |  |
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |   |  | 8 2 0 1 2 7 0                                   |  |
|---|--|---|--|---|--|---|--|---|--|---|--|
| 1 - FOR<br>STATE<br>REGISTRAR   |  | REG. NO.  |  |   |  |   |  |   |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST<br>JOSEPH   |  | MIDDLE<br>Abraham   |  | LAST<br>MEDLEY  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>01 31 82   |  | 2b. HOUR<br>12.15P.M.                           |  |
| 3. SEX<br>MALE  |  | 4. RACE<br>Black  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>04 02 98  |  | 6. AGE (IN YEARS (LAST BIRTHDAY))<br>83 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS.<br>HOURS MIN.                  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)<br>Md.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Bon Secours Hospital |  |   |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Farmer  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY            |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>St Mary's  |  | 13c. CITY OR TOWN<br>Oakville   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>Rt. 24, Box 189 Mechanicsville   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Johnny Medley   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>unknown  |  |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>213 22 0282A  |  | 17. INFORMANT<br>Charles A. Medley  |  |   |  | ADDRESS<br>same as 13 above   |  |   |  |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>1850 IMMEDIATE CAUSE (a) CA of prostate metastasis<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |   |  |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |   |  |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/30/82 to 1/31/82, that (I) (we) lost<br>saw the deceased alive on 1/30/82 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) did not view the body after death.  |  |   |  |   |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br>Kuanyen Huang M.D.  |  | DEGREE<br>M.D.  |  | ATTENDING<br>PHYSICIAN <input checked="" type="checkbox"/> MEDICAL<br>DIRECTOR <input type="checkbox"/> STAFF<br>PHYSICIAN <input type="checkbox"/>         |  | 22c. DATE SIGNED<br>1/31/82   |  |   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>KUANG-YEN HUANG  |  |   |  | 22e. ADDRESS<br>BON Secours Hospital  |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>Feb. 3, 1982   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Charles Memorial Gardens Leonardtown, St Mary's, Md.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>W. Clarke Mattingley Leonardtown, Maryland  |  |   |  | 25a. DATE RECEIVED BY REGISTRAR<br>FEB 5 1982   |  | 25b. SIGNATURE<br>[Signature]   |  |   |  |   |  |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

DHMH-16 30M 2/80  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  |  | REG. NO.   |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>ALICE ELIZABETH MELAMET  |  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR 01 22 82  |  |  |  |  |
| 3. SEX Female  |  |  |  |  | 4. RACE White  |  |  |  |  |
| 5. DATE OF BIRTH MONTH DAY YEAR 01 21 82   |  |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.  |  |  |  |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.   |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.  |  |  |  |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH Balto.   |  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital                      |  |  |  |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY Balto. 13c. CITY OR TOWN Balto.   |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS 761 West Hill's Parkway 21229 |  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST Stephen A. Riley   |  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Grace Richie  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No   |  |  |  |  | 16b. SOCIAL SECURITY NO. 214-12 0882   |  |  |  |  |
| 17. INFORMANT 761 West Hills Pkwy., Doris R. McMahon Balto., Md. 21229   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CORONAR NEURASM, PROBABLY GLIOMATOMA<br>1919<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>LOWER GASTROINTESTINAL HEMORRHAGE   |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  |  |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>                        |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  |  |  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |  | 21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  |  |  |
| 21e. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/21/82, 1982, to 1/22, 1982, that (I) (we) lost saw the deceased alive on 1/22, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE W. Bradley Pifalo MD  |  |  |  |  | 22c. DATE SIGNED 1/22/82   |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) W. BRADLEY PIFALO  |  |  |  |  | 22e. ADDRESS ST. AGNES HOSPITAL  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial   |  |  |  |  | 23b. DATE 1-25-82  |  |  |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery   |  |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.   |  |  |  |  |
| 24. FUNERAL DIRECTOR G. Truman Schwab, P.A. 5151 Balto. Nat'l. Pike, 21229   |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR JAN 27 1982  |  |  |  |  |
| 25b. REGISTRAR'S SIGNATURE James J. Nathan   |  |  |  |  |  |  |  |  |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 72 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                         |  |  |   |                  |   |  |   |  | REG. NO. 2 0 1 2 7 2                         |  |
|--|-------------------------|--|--|---|------------------|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Nevett C. Mele</b>  |                         |  |  |   |                  | 2a. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> <b>Jan 13 19 82</b>     |  | 2b. HOUR <b>p M</b>   |  |  |  |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Sept 14 1892</b>  | 6. AGE IN YEARS<br>(LAST BIRTHDAY)<br><b>89 YRS.</b> | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD<br><b>19 M</b>   |  | 2d. HOUR <b>M</b>   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>5708 Birchwood Ave. (Residence)</b> |  |   |                  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>               |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| 13a. STATE<br><b>Maryland</b>  |                         | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |                  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>Balt., Md. 21214<br/>5708 Birchwood Avenue</b>            |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Ellwood Claude</b>  |                         |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Gannon</b>   |                  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>   |                         | 16b. SOCIAL SECURITY NO.<br><b>214-14-0525</b>   |  | 17. INFORMANT <b>Husband:</b> ADDRESS <b>Balt., Md. 21214<br/>Hugo Mele 5708 Birchwood Avenue</b>   |                  |   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b><br>4292<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). |                         |  |  |   |                  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 19a. DATE OF OPERATION   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |                  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |                  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                  |   |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .  |                         |  |  |   |                  |   |  |   |  |  |  |
| ACTUAL SIGNATURE<br><b>Virginia L. Dolan</b>   |                         | TITLE (SPECIFY)<br><b>Assistant</b>  |  |   |                  | DATE SIGNED<br><b>1-14-82</b>   |  |   |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Virginia L. Dolan, M.D.</b>   |                         | ADDRESS<br><b>111 Penn Street</b>  |  |   |                  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |                         | 23b. DATE<br><b>Jan 16 1982</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cemetery</b>  |                  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>                         |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J. Ruck, Inc.</b>   |                         |  |  | ADDRESS<br><b>Baltimore, Maryland</b>   |                  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 19 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>James J. Nathan</b>                                |  |  |  |

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2521-11



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |   |   | REG. NO.  |  |
|---|--|--|--|--|--|--|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Lee Carroll Melvin</b>   |  |  |  |  |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>1 30 1982</b> |  | 2b. HOUR <b>M</b>   |   |   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>10 5 55</b>                  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>26 YRS.</b>  |  | 7. IF UNDER 1 YR. MONTHS DAYS   |   | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR <b>1 30 1982</b>                         |  |
| 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City,</b> MD. |  |  |  |   |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Agnes Hospital</b>                  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Painting Contractor</b>              |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Self-employ</b> |   |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Catonsville</b>                            |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>          |  | 13e. STREET ADDRESS<br><b>108 Melvin Avenue</b>                         |   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Lee C. Melvin Sr.</b>  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Genevieve Crehan</b>                                 |  |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>213-68-7318</b>                     |  | 17. INFORMANT<br><b>Ronald P. Melvin</b>   |  | ADDRESS<br><b>3010 Chestnut Hill Dr<br/>Ellicott City, Md.</b>          |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b><br>4100<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |  |  |  |  |  |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).   |  |  |  |  |  |  |  |   |   |   |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                  |  |  |  |   |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19         |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                            |  |   |   |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)        |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |   |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |  |  |  |  |   |   |   |  |
| ACTUAL SIGNATURE<br><i>Thomas D. Smith</i>  |  |  |  |  |  | TITLE (SPECIFY)<br><b>Deputy Chief</b>   |  |   | DATE SIGNED<br><b>1/31/82</b>                           |   |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Thomas D. Smith, M.D.</b>   |  |  |  |  |  | ADDRESS<br><b>111 Penn St. Balto., MD.</b>   |  |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>2/3/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Crestlawn Cemetery</b>    |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Marriottsville Md.</b> |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Witzke P.A.</b>  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 3 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Thomas D. Smith</i>                    |   |   |  |
| 1630 Edmondson Avenue, Catonsville, Md. 21228   |  |  |  |  |  |  |  |   |   |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 2 0 1 2 7 4   |  |  |   |
|---|--|---|--|---|--|--|---|
| 1. FOR STATE REGISTRAR  |  |   |  | REG. NO.  |  |  |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>WILLIE M MERCER</b>  |  |   |  | 2a. DATE OF DEATH<br>MONTH <b>01</b> DAY <b>31</b> YEAR <b>82</b>   |  |  |   |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>BLACK</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>04</b> DAY <b>05</b> YEAR <b>30</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>51</b> YRS.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>SC</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University of Maryland Hosp</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>unemployed</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>—   |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Baltimore</b>   |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>1149 N Sticker St</b>  |   |
| 14. FATHER'S NAME<br>FIRST <b>CALHOUN</b> MIDDLE <b>J</b> LAST <b>ANDREWS</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>MAUDE</b> MIDDLE <b>BYRD</b> LAST <b>BYRD</b>  |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>214 30 4577</b>  |  | 17. INFORMANT<br><b>DAVIS, EDITH B</b>  |  | ADDRESS<br><b>1713 Baker St Baltimore MD 21217</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiac pulmonary arrest</b><br><b>1790</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>CNS metastasis</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cancer of uterus</b>   |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 weeks</b><br><b>6 mos.</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.   |  |   |  |   |  |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)  |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>01/30/82</b> 19 <b>82</b> to <b>01/31/82</b> 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>3:30 AM 01/31</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |   |
| 22b. SIGNATURE<br><b>Jaime M. Vasquez</b>   |  |   |  | DEGREE<br><b>M.D.</b>   |  | 22c. DATE SIGNED<br><b>01/31/82</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JAIME M. VASQUEZ, MD.</b>   |  |   |  | 22e. ADDRESS<br><b>Univ of Maryland Hospital Balto, MD</b>  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>  |  | 23b. DATE<br><b>2/5/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Auburn</b>   |  | 23d. LOCATION<br>CITY OR TOWN <b>Westport</b> COUNTY <b>Md</b> STATE   |   |
| 24. FUNERAL DIRECTOR<br><b>Chas. A. Rice FSPA 1300 Eutaw Place</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>FEB 5 1982</b> 25b. REGISTRAR'S SIGNATURE<br><b>Thane J. [Signature]</b>   |  |  |   |



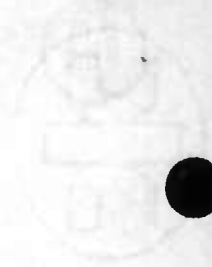
Chart. N. 1100-1300 - New Place  
2/2/82  
1/1/82

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 (if any) to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| FOR<br>1 - STATE<br>REGISTRAR   |  |  |  | #2a, b, 6, 6, Filmg573 11/10/82 kam STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                    |  |   |  | 8 2 0 1 2 7 5<br>REG. NO.  |  |  |  |
|---|--|--|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Baby Girl Meredith</i>   |  |  |  | 2a. DATE OF DEATH<br>MONTH <i>1</i> DAY <i>4</i> YEAR <i>82</i>   |  |   |  | 2b. HOUR<br><i>6:03 A</i>  |  |  |  |
| 3. SEX<br><i>Female</i>   |  | 4. RACE<br><i>N</i>  |  | 5. DATE OF BIRTH<br>MONTH <i>1</i> DAY <i>2</i> YEAR <i>52</i>  |  | 6. AGE (IN YEARS (LAST BIRTHDAY))<br>YRS <i>0</i> MONTHS <i>0</i> DAYS <i>1</i> HOURS <i>37</i> |  | IF UNDER 1 YEAR<br>MONTHS <i>0</i> DAYS <i>0</i>   |  | IF UNDER 24 HRS.<br>HOURS <i>1</i> MIN <i>37</i> |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY) <i>Maryland</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.                               |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>St. Agnes Hospital</i> |  |   |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>none</i>  |  | 12b. KIND OF BUSINESS OR INDUSTRY                |  |
| 13a. STATE<br><i>Maryland</i>   |  | 13b. COUNTY<br><i>Baltimore</i>  |  | 13c. CITY OR TOWN<br><i>Baltimore</i>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><i>2229 N. Ellamont Street 21216</i>  |  |  |  |
| 14. FATHER'S NAME<br>FIRST <i>Marlin</i> MIDDLE <i>UNKNOWN</i> LAST <i>Summerfield</i>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <i>Cynthia Mae</i> MIDDLE <i>Meredith</i> LAST  |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>no</i>   |  | 16b. SOCIAL SECURITY NO.<br><i>none</i>  |  | 17. INFORMANT<br>ADDRESS<br><i>Cynthia Mae Meredith same as # 13</i>  |  |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><i>7651 Cardio - Resp. Arrest</i><br>IMMEDIATE CAUSE (a) <i>Immaturity</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <i>Immaturity</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a  |  |  |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>8/2</i> 19 <i>82</i> to <i>1/2</i> 19 <i>82</i> , that (I) (we) lost saw the deceased alive on <i>1/2</i> 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><i>Aracmaeg</i>   |  |  |  | DEGREE  |  |   |  | 22c. DATE SIGNED   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>ARTHUR L. MACARAEG, M.D.</i>  |  |  |  | 22e. ADDRESS<br><i>St. Agnes Hospital<br/>900 S. Caton Avenue., 21229</i>   |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <i>BURIAL</i>  |  | 23b. DATE<br><i>1/13/82</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>NEW CATHEDRAL</i>  |  | 23d. LOCATION<br><i>4300 OLD FREDERICK RD.</i>  |  | STATE<br><i>BALTO., MD. 21228</i>  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>WITZKE FUN'L HOME</i>  |  |  |  | ADDRESS<br><i>1630 EDMONDSON AVE. BALTO., MD. 21228</i>   |  |   |  | 25. DATE RECEIVED BY REGISTRAR<br><i>JAN 14 1982</i>   |  |  |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |  |  |  |  |   |  | 8 2 0 1 2 7 6  |  |                  |  |
|---|--|--|--|--|--|--|--|---|--|--|--|------------------|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  |  |  | CERTIFICATE OF DEATH   |  |  |  | REG. NO.  |  |  |  |                  |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT)  |  |  |  | FIRST MIDDLE LAST<br><del>ANITA</del> LUCILLE E. MERRIMAN  |  |  |  | 2a DATE OF DEATH MONTH DAY YEAR<br>24 10 82                               |  |  |  | 2b HOUR<br>5 P M |  |
| 3 SEX<br>FEMALE   |  | 4 RACE<br>BLACK  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>11 17 11  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>70 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                 |  | IF UNDER 24 HRS  |  |                  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Chrisfield, MD  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.  |  |   |  |  |  |                  |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore City Hospital |  |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b KIND OF BUSINESS OR INDUSTRY  |  |  |  |                  |  |
| 13a. STATE<br>MD  |  |  |  | 13b. CITY OR TOWN<br>Baltimore   |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e STREET ADDRESS<br>914 E. Pratt St.                                    |  |  |  |                  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles Ashby  |  |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Eva Sterling   |  |  |  |   |  |  |  |                  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  |  |  | 16b SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br>215-09-6440   |  | 17 INFORMANT<br>ADDRESS<br>Anita King Keve 914 E. Pratt St.  |  |   |  |  |  |                  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1: DEATH WAS CAUSED BY:<br>4275 IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |                  |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11a<br>Altered mental status, chronic Renal Failure  |  |  |  |  |  |  |  |   |  |  |  |                  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>PER RECTAL FISTULA   |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |  |                  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |                  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____ to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                   |  |  |  |  |  |  |  |   |  |  |  |                  |  |
| 22b. SIGNATURE<br>Gordon Raphael  |  |  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>11/10/82  |  |  |  |                  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>GORDON RAPHAEL   |  |  |  |  |  | 22e. ADDRESS<br>BALTIMORE CITY HOSPITAL  |  |   |  |  |  |                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |  |  | 23b. DATE<br>1/14/82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Auburn Cem.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore MD                |  |  |  |                  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H, Inc.   |  |  |  |  |  | ADDRESS<br>1101 E. North Ave.  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 12 1982                              |  |  |  |                  |  |
|   |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br>Name: [Signature]                           |  |  |  |                  |  |

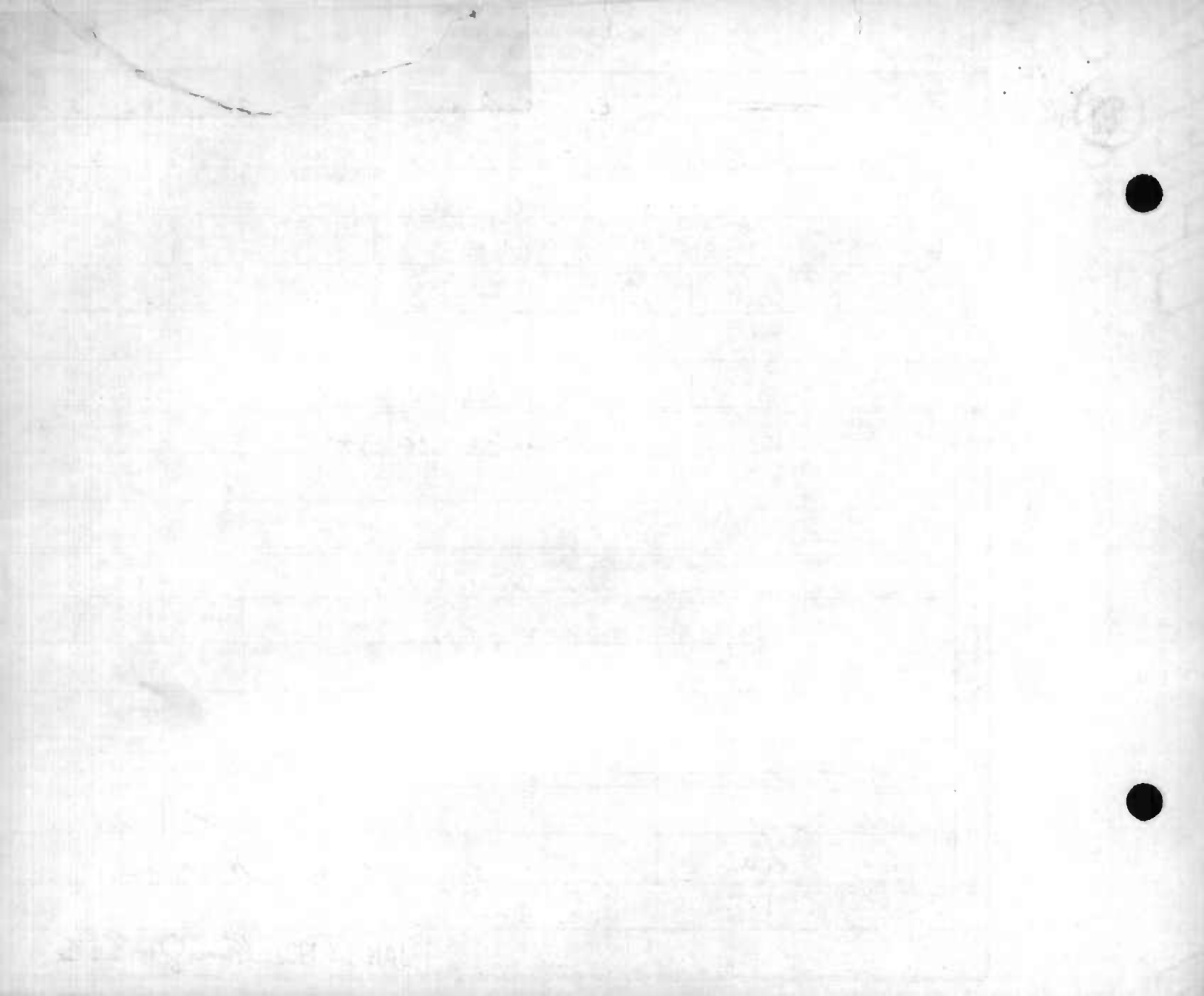
MEDICAL CERTIFICATION

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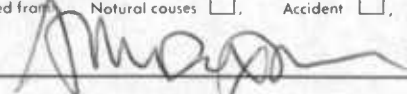

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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15M 2/80

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                  |  |  |  |   |  |   |  | REG. NO. 2 0 1 2 7 7                                       |  |
|---|--|------------------|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>THELMA CATHERINE METZ  |  |                  |  |  |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br>1 19 82                  |  | 2b. HOUR<br>AM  |  |  |  |
| 3. SEX<br>female  |  | 4. RACE<br>white |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Sept. 20, 1905   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>76 YRS.  |  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>1 20 82   |  | 7d. HOUR<br>1:16 PM  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD. |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1507 Greendale Rd. |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Clerk  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>MTA                   |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |                  |  |  |  |   |  |   |  |  |  |
| 13a. STATE<br>Maryland  |  |                  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br>1507 Greendale Rd.                  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles F. Metz   |  |                  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Amelia Alt   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No   |  |                  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>213-05-9691   |  | 17. INFORMANT<br>ADDRESS<br>Wm. F. Rochford 3305 Northway Dr.<br>Balto., Md. 21234                                  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Multiple stab wounds</u><br>9660<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF  |  |                  |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH               |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |                  |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>? P.M. 1-19-1982  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>Subject was stabbed.               |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>home  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>1507 Greendale Rd., Balto. Md.                                 |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                  |  |  |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE   |  |                  |  | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER   |  |   |  | DATE SIGNED 1-21-82   |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Ann M. Dixon, M.D.   |  |                  |  | ADDRESS<br>111 Penn St.  |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |                  |  | 23b. DATE<br>Jan. 23, 1982   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Druid Ridge   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Pikesville, Balto. Co., Md.   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212   |  |                  |  | 25a. DATE RECEIVED BY REGISTRAR<br>JAN 27 1982   |  | 25b. REGISTRAR'S SIGNATURE<br> |  |   |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 8 2 0 1 2 7 8   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1 - FOR STATE REGISTRAR  |  |  |  | REG. NO.  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><i>William O. Meyers</i>   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>1 23 82</i>  |  |   |  |
| 3. SEX<br><i>male</i>  |  | 4. RACE<br><i>white</i>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>2 15 1911</i>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br><i>70</i>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>MD</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>US</i>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>University Hospital</i> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Cab</i>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Driver</i>  |  |
| 13a. STATE<br><i>Maryland</i>  |  |  |  | 13b. COUNTY<br><i>Baltimore City</i>  |  | 13c. CITY OR TOWN<br><i>Baltimore City</i>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>Charles Meyers</i>   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>Annie M. Flint</i>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><i>NO</i>   |  |  |  | 16b. SOCIAL SECURITY NO.<br><i>213-10-7857</i>  |  | 17. INFORMANT ADDRESS<br><i>admission records</i>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>cardiac arrest</i><br><i>1460</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>pneumonia</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) <i>advanced tonsillar squamous cell carcinoma</i><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>minutes</i><br><i>2 weeks</i><br><i>4 years</i> |  |  |  |   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><i>perforated duodenal ulcer</i>  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION<br><i>1/6/82</i>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>perforated duodenal ulcer</i>   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <i>1/6</i> , 19 <i>82</i> , to <i>1/23</i> , 19 <i>82</i> , that (1) (we) last saw the deceased alive on <i>1/23</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><i>Harold G. Roberts, MD</i>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br><i>1/23/82</i>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Harold G. Roberts, Jr.</i>   |  |  |  | 22e. ADDRESS<br><i>1111 Park Ave #1605 Balt MD 21201</i>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>   |  | 23b. DATE<br><i>1/27/82</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Lorraine Park Cemetery Woodlawn</i>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><i>Baltimore City MD</i>   |  |
| 24. FUNERAL DIRECTOR<br><i>Burgee Funeral Home 3631 Falls Road 21211</i>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><i>JAN 26 1982</i>   |  |   |  |

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UNITED STATES DEPARTMENT OF THE INTERIOR

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1955

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

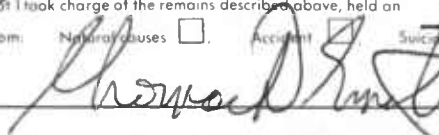
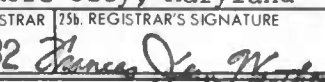
REG. NO.

|  |         |  |  |   |  |   |  |                                      |  |                                |  |       |  |      |  |          |  |
|--|---------|--|--|---|--|---|--|--------------------------------------|--|--------------------------------|--|-------|--|------|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         | FIRST  |  | MIDDLE  |  | LAST  |  | 2a. DATE KNOWN<br>OF DEATH           |  | MONTH                          |  | DAY   |  | YEAR |  | 2b. HOUR |  |
| LESTER   |         |  |  |   |  | MICHEAL<br>(MICHAELS)   |  | 19                                   |  | 1                              |  | 20    |  | 19   |  | 82       |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS)   |  | IF UNDER 1 YR.  |  | IF UNDER 24 HRS.                     |  | 7c. DATE<br>PRONOUNCED<br>DEAD |  | MONTH |  | DAY  |  | YEAR     |  |
| male   | negro   | 3 15 00  |  | 81 YRS.   |  |   |  |                                      |  | 1                              |  | 20    |  | 19   |  | 82       |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)   |         | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED  |  | NEVER MARRIED   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |                                |  |       |  |      |  |          |  |
| S.C.   |         | USA  |  | WIDOWED   |  | DIVORCED  |  | Baltimore City                       |  |                                |  |       |  |      |  |          |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)   |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)              |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY                                |  |                                      |  |                                |  |       |  |      |  |          |  |
| Baltimore  |         | 1415 Ashland Ave.  |  |   |  |   |  |                                      |  |                                |  |       |  |      |  |          |  |
| 13a. STATE   |         | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS                  |  |                                |  |       |  |      |  |          |  |
| MD   |         |  |  | Baltimore   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 1415 Ashland Ave.                    |  |                                |  |       |  |      |  |          |  |
| 14. FATHER'S NAME  |         | 15. MOTHER'S MAIDEN NAME   |  |   |  |   |  |                                      |  |                                |  |       |  |      |  |          |  |
| Dozier   |         | Micheal  |  | Peggy   |  | Sampson   |  |                                      |  |                                |  |       |  |      |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |         | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | ADDRESS   |  |                                      |  |                                |  |       |  |      |  |          |  |
| No   |         | 217-05-7475  |  | Margaret Bristol  |  | 401 E. 25th St.   |  |                                      |  |                                |  |       |  |      |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH  |  |   |  |   |  |                                      |  |                                |  |       |  |      |  |          |  |
| PART I DEATH WAS CAUSED BY:  |         |  |  |   |  |   |  |                                      |  |                                |  |       |  |      |  |          |  |
| IMMEDIATE CAUSE (a)  |         | Arteriosclerotic cardiovascular disease  |  |   |  |   |  |                                      |  |                                |  |       |  |      |  |          |  |
| 4392   |         |  |  |   |  |   |  |                                      |  |                                |  |       |  |      |  |          |  |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a) stating the under-<br>lying cause last.   |         |  |  |   |  |   |  |                                      |  |                                |  |       |  |      |  |          |  |
| (b)  |         |  |  |   |  |   |  |                                      |  |                                |  |       |  |      |  |          |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |  |  |   |  |   |  |                                      |  |                                |  |       |  |      |  |          |  |
| (c)  |         |  |  |   |  |   |  |                                      |  |                                |  |       |  |      |  |          |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |  |  |   |  |   |  |                                      |  |                                |  |       |  |      |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).                            |         |  |  |   |  |   |  |                                      |  |                                |  |       |  |      |  |          |  |
| Progressive muscular atrophy   |         |  |  |   |  |   |  |                                      |  |                                |  |       |  |      |  |          |  |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 20. AUTOPSY?  |  |   |  |                                      |  |                                |  |       |  |      |  |          |  |
|  |         |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |  |   |  |                                      |  |                                |  |       |  |      |  |          |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                      |         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |   |  |                                      |  |                                |  |       |  |      |  |          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> |         | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |   |  |                                      |  |                                |  |       |  |      |  |          |  |
|  |         |  |  |   |  |   |  |                                      |  |                                |  |       |  |      |  |          |  |
| 22a. I certify that I took charge of the remains described above, held an  |         | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion   |  |   |  |   |  |                                      |  |                                |  |       |  |      |  |          |  |
| death resulted from:   |         | Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |   |  |                                      |  |                                |  |       |  |      |  |          |  |
| ACTUAL<br>SIGNATURE  |         | TITLE (SPECIFY)  |  | DATE<br>SIGNED  |  |   |  |                                      |  |                                |  |       |  |      |  |          |  |
| Ann M. Dixon, M.D.   |         | M.D. Assistant   |  | 1-21-82   |  |   |  |                                      |  |                                |  |       |  |      |  |          |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |         | ADDRESS  |  |   |  |   |  |                                      |  |                                |  |       |  |      |  |          |  |
|  |         | 111 Penn St.   |  |   |  |   |  |                                      |  |                                |  |       |  |      |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |         | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN                                       |  |                                      |  |                                |  |       |  |      |  |          |  |
| Burial   |         | 1/25/82  |  | Md. Nat'l Mem. Pk.  |  | Laurel  |  |                                      |  |                                |  |       |  |      |  |          |  |
| 24. FUNERAL DIRECTOR<br>NAME   |         | ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S<br>SIGNATURE                                       |  |                                      |  |                                |  |       |  |      |  |          |  |
| Wm. C. March F/H   |         | 1101 E. North Ave.   |  | JAN 22 1982   |  | Charles J. Harrison   |  |                                      |  |                                |  |       |  |      |  |          |  |

Handwritten text at the bottom left, possibly a signature or date: "JAN 25 1962" and "Lafayette".



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                             |   |  |   |  |  |   |   | REG. NO.   |  |
|---|--|-----------------------------|---|--|---|--|--|---|---|--|--|
| FOR<br>1- STATE REGISTRAR   |  |                             |   |  |   |  |  |   |   |  |  |
| 1. DECEASED NAME FIRST MIDDLE LAST<br>Peter Edwards Michaels  |  |                             |   |  |   |  |  |   |   | 2b. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1 10 19 82                |  |
| 3. SEX male   |  | 4. RACE white               |   | 5. DATE OF BIRTH MONTH DAY YEAR May 3, 1929                      |   | 6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS.  |  | 7c. DATE PRONOUNCED DEAD 1 11 19 82   |   | 2d. HOUR M 8:50  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri  |  |                             | 7b. CITIZEN OF WHAT COUNTRY? USA  |  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. |  |  |
| 10. CITY OR TOWN OF DEATH Baltimore   |  |                             | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1922 South Road |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Art Restorer |   |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |                             |   |  |   |  |  |   |   |  |  |
| 13a. STATE Maryland   |  | 13b. COUNTY Baltimore       |   | 13c. CITY OR TOWN Mt. Washington                                 |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS 1922 South Rd.  |   |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST Eldon Wilson Michaels   |  |                             |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gertrude Edwards |  |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes  |  | (IF YES, GIVE WAR OR DATES) |   | 16b. SOCIAL SECURITY NO. 497-28-4959                             |   | 17. INFORMANT ADDRESS Karen Michaels 724 St. Johns Rd. 21210   |  |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Multiple stabwounds and blunt force injury of head and neck<br>9660<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |                             |   |  |   |  |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |                             |   |  |   |  |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  |                             |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                |   |  |  |   |   | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                 |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CAUSE OF DEATH <input type="checkbox"/>  |  |                             |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. est 1/10/82  |   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) found stabbed |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>   |  |                             |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home |   |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1922 South Road, Baltimore MD                |   |  |  |
| 22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>   |  |                             |   |  |   |  |  |   |   |  |  |
| ACTUAL SIGNATURE   |  |                             |   | TITLE (SPECIFY) M.D. Deputy Chief                                |   |  |  | DATE SIGNED 1/11/82   |   |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.   |  |                             |   | ADDRESS 111 Penn Street, Balto. MD 21201                         |   |  |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation   |  |                             | 23b. DATE Jan. 14, 1982   |  | 23c. NAME OF CEMETERY OR CREMATORY Green Mount              |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City, Maryland                            |   |  |  |
| 24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home, Inc. Balto., Md.   |  |                             |   |  |   | ADDRESS 6500 York Rd/  |  | 25a. DATE REC'D. BY REGISTRAR JAN 20 1982   |   | 25b. REGISTRAR'S SIGNATURE  |  |

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |
|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>John Mihialovici</b>  |  | 2a. DATE OF DEATH<br>MONTH <b>1</b> DAY <b>29</b> YEAR <b>82</b> 2b. HOUR <b>3:45</b> P.M.  |  |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH <b>05</b> DAY <b>11</b> YEAR <b>22</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>59</b> YRS. MONTHS <b>59</b> DAYS <b>59</b> HOURS <b>59</b> MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Ohio</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                      |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SINGL FACILITY, GIVE STREET ADDRESS)<br><b>Sinai Hosp Sinai Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Iron Worker</b>                 |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. CITY OR TOWN<br><b>Baltimore</b>   | 13c. STREET ADDRESS<br><b>203 E. Atholgate Lane</b>  |
| 14. FATHER'S NAME<br>FIRST <b>George</b> MIDDLE <b>Mihialovici</b> LAST <b>Victoria</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Victoria</b> MIDDLE <b>Sebrea</b> LAST <b>Sebrea</b>   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>Yes</b> (IF YES, GIVE WAR OR DATES) <b>WWII</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>214-16-5156</b>  |  |
| 17. INFORMANT<br><b>John Mihialovici</b>  |  | ADDRESS<br><b>5 Ralden Ct., Balt. Md.</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Exsanguination</b><br>5/7/82<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Bleeding esophageal Varices</b><br>(c) <b>Cirrhosis</b>                                 |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>Inoperable Squamous cell Cancer of Lung</b>  |  |   |  |
| 19a. DATE OF OPERATION<br><b>5/7/82</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Squamous cell Cancer of Lung</b>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 20b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |  |
| 21a. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21b. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |
| 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  | 21d. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>01-12</b> , 19 <b>82</b> , to <b>1/29</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>1-29</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |
| 22b. SIGNATURE<br><b>Elio Raul Novoa</b>  |  | 22c. DATE SIGNED<br><b>1/29/82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Elio Raul Novoa</b>   |  | 22e. ADDRESS<br><b>Sinai Hospital, Baltimore, Md.</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>2/2/82</b>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oaklawn Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN <b>Baltimore</b> COUNTY <b>Md.</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Witzke P.A.</b> ADDRESS <b>1630 Edmondson Avenue, Catonsville, Md. 21228</b>  |  | 25a. DATE REC'D. BY REGISTRAR <b>FEB 3 1982</b> 25b. REGISTRAR'S SIGNATURE <b>Thome Jan Nether</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

3-10-1911

10-11-1911

11-12-1911

12-13-1911

13-14-1911

14-15-1911

15-16-1911

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17-18-1911

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19-20-1911

20-21-1911

21-22-1911

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5-6-1912

6-7-1912

7-8-1912

8-9-1912

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN VITAL FILES. AFTER 24 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                      |  |  |  |   |  |   |  | REG. NO. 2 0 1 2 8 2  |  |
|--|--|----------------------|--|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Calvin L. Miller</b>  |  |                      |  |  |  |   |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> <b>1-9-82</b>  |  | 2b. HOUR <b>4:19 AM</b>   |  |
| 3. SEX <b>male</b>   |  | 4. RACE <b>black</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>7-5-47</b>   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <b>34</b> YRS.                             |  | 7c. DATE PRONOUNCED DEAD <b>1-9-82</b>  |  | 7d. HOUR <b>4:19 AM</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md</b>  |  |                      |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>  |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |  |                      |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3004 Harlem Avenue</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |   |  |
| 13a. STATE <b>Md</b>   |  |                      |  | 13b. COUNTY  |  | 13c. CITY OR TOWN <b>BALTO</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS <b>3004 Harlem Ave</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>Charles Miller</b>   |  |                      |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Dorothy Giles</b>            |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>NO</b>  |  |                      |  | 16b. SOCIAL SECURITY NO. <b>215-46-7661</b>  |  | 17. INFORMANT <b>MARY MARSHALL</b>  |  |   |  | ADDRESS <b>733 BRAVER BROOK Rd</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Intravenous narcotism</b><br>3049<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF  |  |                      |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1   |  |                      |  |  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                      |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                      |  |  |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE <b>Margarita A. Korell</b>  |  |                      |  | TITLE (SPECIFY) <b>Assistant</b>   |  |   |  | DATE SIGNED <b>1-9-82</b>   |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>   |  |                      |  | ADDRESS <b>111 Penn Street</b>   |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>  |  |                      |  | 23b. DATE <b>1/13/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>King Mem PK</b>                         |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>Bandallstown Md</b>                   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Vernon R. Bailey</b> ADDRESS <b>1348 N. Calhoun St</b>   |  |                      |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>JAN 18 1982</b>                              |  |   |  |   |  |

1 JAN 18 1985  
JAN 18 1985

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. For the purpose of this law, the death certificate is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR  |  |  |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 8 2 0 1 2 8 3  |  |  |  |
|---|--|--|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  |  | 2a. DATE OF DEATH  |  |   |  | 2b. HOUR   |  |  |  |
| GARTHILA B. MILLER  |  |  |  | 01-29-82   |  |   |  | 6:50 P.M.  |  |  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                       |  | IF UNDER 1 YEAR  |  | IF UNDER 4 HRS.  |  |
| FEMALE  |  | B  |  | 09-01-89   |  | 72 YRS.   |  | MONTHS   |  | DAYS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                  |  |  |  |  |  |
| VIRGINIA  |  | U.S.A.   |  |  |  | CITY MD.  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)         |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| BALTIMORE   |  | LUTHERAN HOSP. OF MD.  |  |  |  | RETIRED   |  |  |  |  |  |
| 13a. STATE  |  |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?   |  | 13e. STREET ADDRESS  |  |
| MD  |  |  |  |  |  | BALTIMORE   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 1620 MORELAND AVENUE   |  |
| 14. FATHER'S NAME   |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |   |  |  |  |  |  |
| Daniel Paige  |  |  |  | Mary   |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  |  |  |  |  |
| No  |  |  |  | 215 323475   |  | Lloyd Miller 1620 Moreland Ave. ADDRESS: MEHMT. THAUNG LUTHERAN HOSP. |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |  |  |   |  |  |  |  |  |
| IMMEDIATE CAUSE (a) Gram negative sepsis, Multi-organ   |  |  |  |  |  |   |  |  |  |  |  |
| 5741 DUE TO, OR AS A CONSEQUENCE OF systemic failure  |  |  |  |  |  |   |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |  |  |   |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |   |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
| 1-13-82   |  |  |  | cholecystitis, cholelithiasis  |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
|   |  |  |  | HOUR A.M. MONTH DAY YEAR   |  |   |  |  |  |  |  |
|   |  |  |  | P.M. 19  |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |   |  | 21f. LOCATION  |  |  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  |  |  |   |  | CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (a) (this hospital) attended the deceased from 1-7-82, 1982, to 1-29-82, 1982, that (we) lost saw the deceased alive on 1-29-82, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE  |  |  |  | DEGREE   |  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED   |  |
| MEHMT. THAUNG   |  |  |  |  |  |   |  |  |  | 1-29-82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | 22e. ADDRESS   |  |   |  |  |  |  |  |
| MEHMT. THAUNG   |  |  |  | LUTHERAN HOSP. OF MD.  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |   |  | 23d. LOCATION  |  |  |  |
| Burial  |  | 2/4/82   |  | Mt. Calvary  |  |   |  | Baltimore Co. MD   |  |  |  |
| 24. FUNERAL DIRECTOR  |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  |   |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |
| Wm. C. March F/H 1101 E. North Ave.   |  |  |  | FEB 4 1982   |  |   |  | Howe Jan North   |  |  |  |

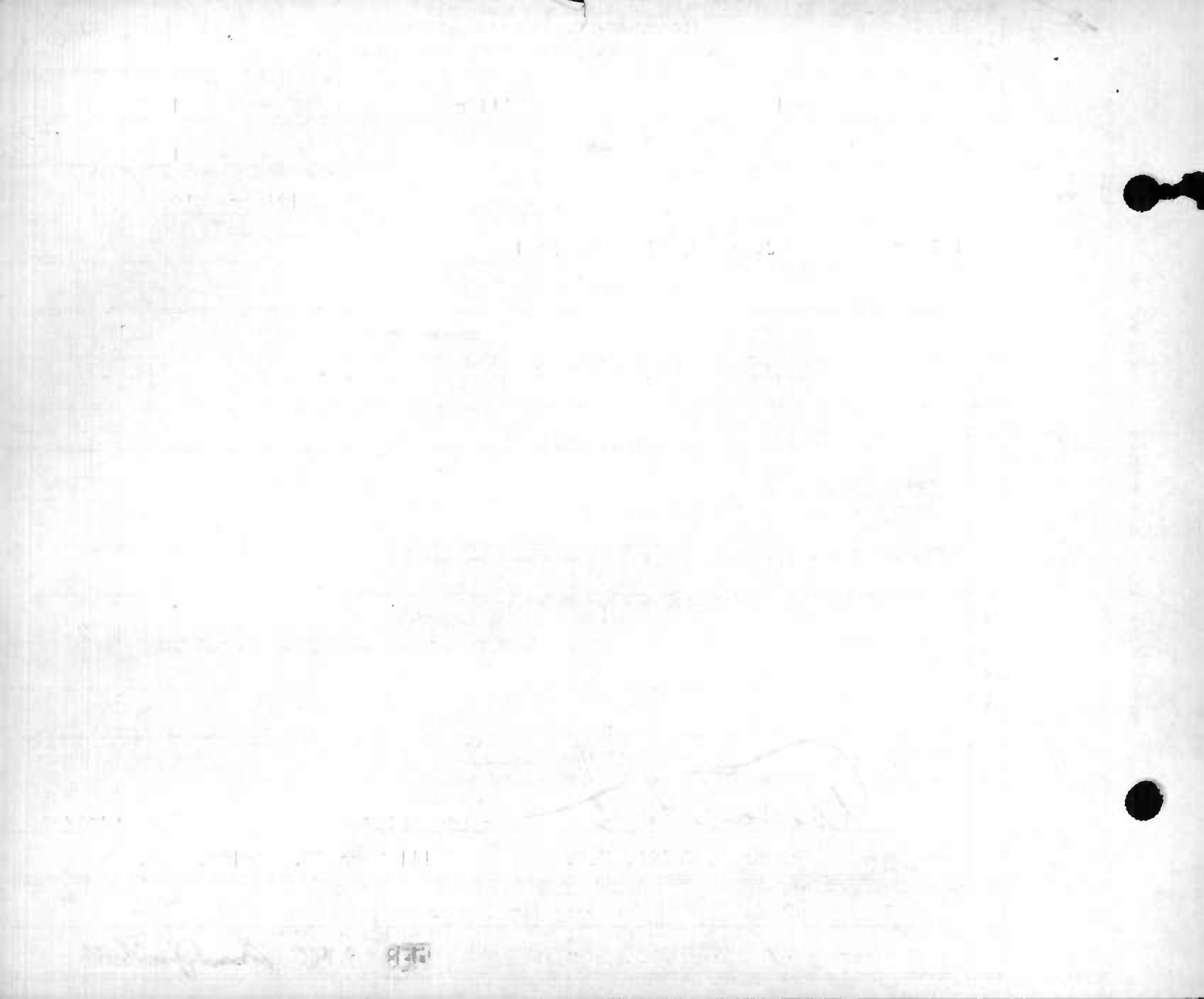




|  |         |   |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |           |  |
|--|---------|---|--|---|--|---|--|--------------------------------------|--|--------------------------|--|-------|--|------|--|-----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         | FIRST   |  | MIDDLE  |  | LAST  |  | 2a. DATE KNOWN OF DEATH              |  | MONTH                    |  | DAY   |  | YEAR |  | 2b. HOUR  |  |
| Harold   |         | Miller  |  |   |  |   |  | 1                                    |  | 30                       |  | 1982  |  |      |  | M         |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS)   |  | IF UNDER 1 YR.  |  | IF UNDER 24 HRS.                     |  | 7c. DATE PRONOUNCED DEAD |  | MONTH |  | DAY  |  | YEAR      |  |
| Male   | Black   | 10 1 58   |  | 23 YRS.   |  | MONTHS  |  | DAYS                                 |  | 1                        |  | 30    |  | 1982 |  | 12:08 a M |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?                                |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |                          |  |       |  |      |  | MD.       |  |
| MD   |         | USA   |  |   |  |   |  | Baltimore City,                      |  |                          |  |       |  |      |  |           |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION    |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                         |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                                      |  |                          |  |       |  |      |  |           |  |
| Baltimore  |         | Johns Hopkins Hospital                                      |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |           |  |
| 13a. STATE   |         | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS                  |  |                          |  |       |  |      |  |           |  |
| MD   |         | Baltimore   |  | Baltimore   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 653 Bartlett Ave.                    |  |                          |  |       |  |      |  |           |  |
| 14. FATHER'S NAME  |         | 15. MOTHER'S MAIDEN NAME                                    |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |           |  |
| Curtis   |         | H. Miller   |  | Genevieve   |  | Only  |  | Miller                               |  |                          |  |       |  |      |  |           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?   |         | 16b. SOCIAL SECURITY NO.                                    |  | 17. INFORMANT   |  | ADDRESS   |  |                                      |  |                          |  |       |  |      |  |           |  |
| No   |         | 214-72-2172   |  | Patricia Miller   |  | 653 Bartlett Ave.   |  |                                      |  |                          |  |       |  |      |  |           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |           |  |
| PART I DEATH WAS CAUSED BY:  |         |   |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |           |  |
| 3049 IMMEDIATE CAUSE (a) Narcotism   |         |   |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |           |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |   |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |           |  |
| (b)  |         |   |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |           |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |   |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |           |  |
| (c)  |         |   |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |           |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |         |   |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |           |  |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  | 20. AUTOPSY?  |  |   |  |                                      |  |                          |  |       |  |      |  |           |  |
|  |         |   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                   |  |   |  |                                      |  |                          |  |       |  |      |  |           |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)         |  |   |  |                                      |  |                          |  |       |  |      |  |           |  |
|  |         | P.M. 19   |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |           |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  | 21f. LOCATION   |  |   |  |                                      |  |                          |  |       |  |      |  |           |  |
|  |         |   |  | CITY OR TOWN  |  | COUNTY  |  | STATE                                |  |                          |  |       |  |      |  |           |  |
| 22a. I certify that I took charge of the remains described above; field in death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |         |   |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |           |  |
| ACTUAL SIGNATURE   |         | TITLE (SPECIFY)   |  | DATE SIGNED   |  |   |  |                                      |  |                          |  |       |  |      |  |           |  |
| Thomas D. Smith, M.D.  |         | M. Deputy Chief   |  | 1/30/82   |  |   |  |                                      |  |                          |  |       |  |      |  |           |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |         | ADDRESS   |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |           |  |
| Thomas D. Smith, M.D.  |         | III Penn St. Balto., MD.                                    |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |           |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |         | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION   |  |                                      |  |                          |  |       |  |      |  |           |  |
| Burial   |         | 2/3/82  |  | Arbutus Mem. Park   |  | Baltimore   |  | Co.                                  |  | MD                       |  |       |  |      |  |           |  |
| 24. FUNERAL DIRECTOR   |         | 25a. DATE REC'D. BY REGISTRAR                               |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |                                      |  |                          |  |       |  |      |  |           |  |
| Wm. C. March F/H   |         | FEB 2 1982  |  | Thomas D. Smith   |  |   |  |                                      |  |                          |  |       |  |      |  |           |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8 2 0 1 2 8 5<br>REG. NO.   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>HARRY L. MILLER</b>   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>JAN 3 1982</b> 2b. HOUR <b>5:28 PM</b>  |  |   |  |
| 3. SEX <b>Male</b>   |  | 4. RACE <b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>08 05 1991</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>90</b> YRS. MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SINAI HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>M. T. A.</b>   |  |
| 13a. STATE <b>MARYLAND</b>   |  | 13b. CITY OR TOWN <b>BALTIMORE</b>  |  | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13d. STREET ADDRESS <b>4111 Hayward Ave. Balto., Md. 21215</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Urias Miller</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sarah Keeney</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>no</b> (IF YES, GIVE WAR OR DATES) <b>none</b>   |  | 16b. SOCIAL SECURITY NO. <b>213 10 0062</b>   |  | 17. INFORMANT ADDRESS <b>Mrs. Margaret Miller 4111 Hayward Ave. Balto., Md. 21215</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>MYOCARDIAL INFARCTION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION <b>—</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>JAN 3</b> , 19 <b>82</b> , to <b>JAN 3</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>8-5-82</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did not) view the body after death.  |  |   |  |   |  |   |  |
| 22b. SIGNATURE <b>Craig G. Haber, MD</b>   |  |   |  | DEGREE <b>MD</b>  |  | 22c. DATE SIGNED <b>1/3/82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>CRAIG G. HABER, MD</b>  |  |   |  | 22e. ADDRESS <b>Sinai Hospital of Baltimore</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  | 23b. DATE <b>1-6-82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>Woodlawn Baltimore Maryland</b>   |  |
| 24. FUNERAL DIRECTOR <b>Loring Byers Funeral Directors, Inc.</b><br>NAME ADDRESS <b>8728 Liberty Road Randallstown, Maryland 21133</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>JAN 6 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Frances Jan Nathan</b>  |  |

1980-1981  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please make copies of pages 1 and 2 and should be filed with 1-72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. **RELEASED NON-MED. DR. KORELL**

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once. **PER MR. FREEMAN**

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 2 8 6

|  |  |  |  |
|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>HESTER G. MILLIGAN</b>   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>JANUARY 21, 1982</b>  |  |
| 3. SEX<br><b>Female</b>  |  | 2b. HOUR<br><b>10:55P</b>  |  |
| 4. RACE<br><b>Negro</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>65</b> YRS.  |  |
| 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Feb. 18-1916</b>  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  |  | 8. IF UNDER 74 HRS.<br>HOURS MIN.  |  |
| 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b> |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY  |  |
| 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 13e. STREET ADDRESS<br><b>1935 E. Lafayette Ave.</b>   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Walter Millican</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lula Adams</b>   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>412-183269</b>  |  |
| 17. INFORMANT<br><b>Mrs. Thelma Queen</b>  |  | ADDRESS<br><b>1935 E. Lafayette Ave.</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ISCHEMIC HEART DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 HR</b>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/21</b> , 19 <b>82</b> , to <b>1/21</b> , 19 <b>82</b> , that (I) (we) lost<br>saw the deceased alive on <b>1/21</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |
| 22b. SIGNATURE<br><b>Paula Kinnunen MD</b>   |  | 22c. DATE SIGNED<br><b>1/21/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>PAULA KINNUNEN MD</b>  |  | 22e. ADDRESS<br><b>JOHNS HOPKINS HOSPITAL</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>1-27-82</b>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Calvary Ctry.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Cedar Hill RR Co. Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Randolph J. Collick</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 29 1982</b>  |  |
| ADDRESS<br><b>2431 E. Oliver St.</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Frances Santer</b>  |  |

MEDICAL CERTIFICATION

1. The first part of the document is a list of names.

2. The second part of the document is a list of dates.

3. The third part of the document is a list of times.

4. The fourth part of the document is a list of locations.

5. The fifth part of the document is a list of events.

6. The sixth part of the document is a list of people.

7. The seventh part of the document is a list of things.

8. The eighth part of the document is a list of places.

9. The ninth part of the document is a list of times.

10. The tenth part of the document is a list of dates.

11. The eleventh part of the document is a list of names.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and item 18 completed.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 2 8 7

REG. NO.

|  |   |   |                                      |   |                                   |
|--|---|---|--------------------------------------|---|-----------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |   | 2a. DATE OF DEATH   |                                      | 2b. HOUR  |                                   |
| Joseph Millner   |   | 01/14/82  |                                      | 3:10 PM   |                                   |
| 3. SEX   | 4. RACE   | 5. DATE OF BIRTH  | 6. AGE                               | 7. IF UNDER 1 YEAR  |                                   |
| MALE   | CAUCASIAN   | 01/15/89  | 85 YRS.                              | MONTHS DAYS HOURS MIN   |                                   |
| 8a. BIRTHPLACE   | 7b. CITIZEN OF WHAT COUNTRY?                            | 8. MARRIED  | 9. BALTIMORE CITY OR COUNTY OF DEATH |   |                                   |
| LATVIA   | USA   | NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | BALTIMORE CITY MD                    |   |                                   |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION |   | 12a. USUAL OCCUPATION                |   | 12b. KIND OF BUSINESS OR INDUSTRY |
| BALTIMORE  | Sinai Hospital of Baltimore                             |   | SHOE OPERATOR                        |   | SHOE CO.                          |
| 13a. STATE   |   | 13b. COUNTY   | 13c. CITY OR TOWN                    | 13d. INSIDE CITY LIMITS?  |                                   |
| Maryland   | Baltimore   | Baltimore   | Baltimore                            | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                   |
| 14. FATHER'S NAME  |   | 15. MOTHER'S MAIDEN NAME  |                                      | 13e. STREET ADDRESS   |                                   |
| ISADORE  |   | MOLLIE  |                                      | 6514 Eberle Dr Apt 102 21215  |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?   |   | 16b. SOCIAL SECURITY NO.  |                                      | 17. INFORMANT   |                                   |
| YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> (IF YES, GIVE WAR OR DATES)  |   | WWI-ARMY 212-03-3676  |                                      | MRS. MOLLIE CHMAR   |                                   |
| 18. CAUSE OF DEATH   |   | 19. DATE OF OPERATION   |                                      | 20a. AUTOPSY?   |                                   |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Septicemia prob 2° to UTI<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) CA of prostate<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) CA of stomach |   | 19a. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 18  |   | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH           |                                      | 21b. TIME OF INJURY   |                                   |
|  |   | 21c. HOW INJURY OCCURRED  |                                      | 21d. INJURY OCCURRED  |                                   |
|  |   | 21e. PLACE OF INJURY  |                                      | 21f. LOCATION   |                                   |
|  |   | 21g. DATE OF OPERATION  |                                      | 21h. DATE OF INJURY   |                                   |
|  |   | 21i. DATE OF OPERATION  |                                      | 21j. DATE OF INJURY   |                                   |
|  |   | 21k. DATE OF OPERATION  |                                      | 21l. DATE OF INJURY   |                                   |
|  |   | 21m. DATE OF OPERATION  |                                      | 21n. DATE OF INJURY   |                                   |
|  |   | 21o. DATE OF OPERATION  |                                      | 21p. DATE OF INJURY   |                                   |
|  |   | 21q. DATE OF OPERATION  |                                      | 21r. DATE OF INJURY   |                                   |
|  |   | 21s. DATE OF OPERATION  |                                      | 21t. DATE OF INJURY   |                                   |
|  |   | 21u. DATE OF OPERATION  |                                      | 21v. DATE OF INJURY   |                                   |
|  |   | 21w. DATE OF OPERATION  |                                      | 21x. DATE OF INJURY   |                                   |
|  |   | 21y. DATE OF OPERATION  |                                      | 21z. DATE OF INJURY   |                                   |
|  |   | 21aa. DATE OF OPERATION   |                                      | 21ab. DATE OF INJURY  |                                   |
|  |   | 21ac. DATE OF OPERATION   |                                      | 21ad. DATE OF INJURY  |                                   |
|  |   | 21ae. DATE OF OPERATION   |                                      | 21af. DATE OF INJURY  |                                   |
|  |   | 21ag. DATE OF OPERATION   |                                      | 21ah. DATE OF INJURY  |                                   |
|  |   | 21ai. DATE OF OPERATION   |                                      | 21aj. DATE OF INJURY  |                                   |
|  |   | 21ak. DATE OF OPERATION   |                                      | 21al. DATE OF INJURY  |                                   |
|  |   | 21am. DATE OF OPERATION   |                                      | 21an. DATE OF INJURY  |                                   |
|  |   | 21ao. DATE OF OPERATION   |                                      | 21ap. DATE OF INJURY  |                                   |
|  |   | 21aq. DATE OF OPERATION   |                                      | 21ar. DATE OF INJURY  |                                   |
|  |   | 21as. DATE OF OPERATION   |                                      | 21at. DATE OF INJURY  |                                   |
|  |   | 21au. DATE OF OPERATION   |                                      | 21av. DATE OF INJURY  |                                   |
|  |   | 21aw. DATE OF OPERATION   |                                      | 21ax. DATE OF INJURY  |                                   |
|  |   | 21ay. DATE OF OPERATION   |                                      | 21az. DATE OF INJURY  |                                   |
|  |   | 21ba. DATE OF OPERATION   |                                      | 21bb. DATE OF INJURY  |                                   |
|  |   | 21bc. DATE OF OPERATION   |                                      | 21bd. DATE OF INJURY  |                                   |
|  |   | 21be. DATE OF OPERATION   |                                      | 21bf. DATE OF INJURY  |                                   |
|  |   | 21bg. DATE OF OPERATION   |                                      | 21bh. DATE OF INJURY  |                                   |
|  |   | 21bi. DATE OF OPERATION   |                                      | 21bj. DATE OF INJURY  |                                   |
|  |   | 21bk. DATE OF OPERATION   |                                      | 21bl. DATE OF INJURY  |                                   |
|  |   | 21bm. DATE OF OPERATION   |                                      | 21bn. DATE OF INJURY  |                                   |
|  |   | 21bo. DATE OF OPERATION   |                                      | 21bp. DATE OF INJURY  |                                   |
|  |   | 21bq. DATE OF OPERATION   |                                      | 21br. DATE OF INJURY  |                                   |
|  |   | 21bs. DATE OF OPERATION   |                                      | 21bt. DATE OF INJURY  |                                   |
|  |   | 21bu. DATE OF OPERATION   |                                      | 21bv. DATE OF INJURY  |                                   |
|  |   | 21bw. DATE OF OPERATION   |                                      | 21bx. DATE OF INJURY  |                                   |
|  |   | 21by. DATE OF OPERATION   |                                      | 21bz. DATE OF INJURY  |                                   |
|  |   | 21ca. DATE OF OPERATION   |                                      | 21cb. DATE OF INJURY  |                                   |
|  |   | 21cc. DATE OF OPERATION   |                                      | 21cd. DATE OF INJURY  |                                   |
|  |   | 21ce. DATE OF OPERATION   |                                      | 21cf. DATE OF INJURY  |                                   |
|  |   | 21cg. DATE OF OPERATION   |                                      | 21ch. DATE OF INJURY  |                                   |
|  |   | 21ci. DATE OF OPERATION   |                                      | 21cj. DATE OF INJURY  |                                   |
|  |   | 21ck. DATE OF OPERATION   |                                      | 21cl. DATE OF INJURY  |                                   |
|  |   | 21cm. DATE OF OPERATION   |                                      | 21cn. DATE OF INJURY  |                                   |
|  |   | 21co. DATE OF OPERATION   |                                      | 21cp. DATE OF INJURY  |                                   |
|  |   | 21cq. DATE OF OPERATION   |                                      | 21cr. DATE OF INJURY  |                                   |
|  |   | 21cs. DATE OF OPERATION   |                                      | 21ct. DATE OF INJURY  |                                   |
|  |   | 21cu. DATE OF OPERATION   |                                      | 21cv. DATE OF INJURY  |                                   |
|  |   | 21cw. DATE OF OPERATION   |                                      | 21cx. DATE OF INJURY  |                                   |
|  |   | 21cy. DATE OF OPERATION   |                                      | 21cz. DATE OF INJURY  |                                   |
|  |   | 21da. DATE OF OPERATION   |                                      | 21db. DATE OF INJURY  |                                   |
|  |   | 21dc. DATE OF OPERATION   |                                      | 21dd. DATE OF INJURY  |                                   |
|  |   | 21de. DATE OF OPERATION   |                                      | 21df. DATE OF INJURY  |                                   |
|  |   | 21dg. DATE OF OPERATION   |                                      | 21dh. DATE OF INJURY  |                                   |
|  |   | 21di. DATE OF OPERATION   |                                      | 21dj. DATE OF INJURY  |                                   |
|  |   | 21dk. DATE OF OPERATION   |                                      | 21dl. DATE OF INJURY  |                                   |
|  |   | 21dm. DATE OF OPERATION   |                                      | 21dn. DATE OF INJURY  |                                   |
|  |   | 21do. DATE OF OPERATION   |                                      | 21dp. DATE OF INJURY  |                                   |
|  |   | 21dq. DATE OF OPERATION   |                                      | 21dr. DATE OF INJURY  |                                   |
|  |   | 21ds. DATE OF OPERATION   |                                      | 21dt. DATE OF INJURY  |                                   |
|  |   | 21du. DATE OF OPERATION   |                                      | 21dv. DATE OF INJURY  |                                   |
|  |   | 21dw. DATE OF OPERATION   |                                      | 21dx. DATE OF INJURY  |                                   |
|  |   | 21dy. DATE OF OPERATION   |                                      | 21dz. DATE OF INJURY  |                                   |
|  |   | 21ea. DATE OF OPERATION   |                                      | 21eb. DATE OF INJURY  |                                   |
|  |   | 21ec. DATE OF OPERATION   |                                      | 21ed. DATE OF INJURY  |                                   |
|  |   | 21ee. DATE OF OPERATION   |                                      | 21ef. DATE OF INJURY  |                                   |
|  |   | 21eg. DATE OF OPERATION   |                                      | 21eh. DATE OF INJURY  |                                   |
|  |   | 21ei. DATE OF OPERATION   |                                      | 21ej. DATE OF INJURY  |                                   |
|  |   | 21ek. DATE OF OPERATION   |                                      | 21el. DATE OF INJURY  |                                   |
|  |   | 21em. DATE OF OPERATION   |                                      | 21en. DATE OF INJURY  |                                   |
|  |   | 21eo. DATE OF OPERATION   |                                      | 21ep. DATE OF INJURY  |                                   |
|  |   | 21eq. DATE OF OPERATION   |                                      | 21er. DATE OF INJURY  |                                   |
|  |   | 21es. DATE OF OPERATION   |                                      | 21et. DATE OF INJURY  |                                   |
|  |   | 21eu. DATE OF OPERATION   |                                      | 21ev. DATE OF INJURY  |                                   |
|  |   | 21ew. DATE OF OPERATION   |                                      | 21ex. DATE OF INJURY  |                                   |
|  |   | 21ey. DATE OF OPERATION   |                                      | 21ez. DATE OF INJURY  |                                   |
|  |   | 21fa. DATE OF OPERATION   |                                      | 21fb. DATE OF INJURY  |                                   |
|  |   | 21fc. DATE OF OPERATION   |                                      | 21fd. DATE OF INJURY  |                                   |
|  |   | 21fe. DATE OF OPERATION   |                                      | 21ff. DATE OF INJURY  |                                   |
|  |   | 21fg. DATE OF OPERATION   |                                      | 21fh. DATE OF INJURY  |                                   |
|  |   | 21fi. DATE OF OPERATION   |                                      | 21fj. DATE OF INJURY  |                                   |
|  |   | 21fk. DATE OF OPERATION   |                                      | 21fl. DATE OF INJURY  |                                   |
|  |   | 21fm. DATE OF OPERATION   |                                      | 21fn. DATE OF INJURY  |                                   |
|  |   | 21fo. DATE OF OPERATION   |                                      | 21fp. DATE OF INJURY  |                                   |
|  |   | 21fq. DATE OF OPERATION   |                                      | 21fr. DATE OF INJURY  |                                   |
|  |   | 21fs. DATE OF OPERATION   |                                      | 21ft. DATE OF INJURY  |                                   |
|  |   | 21fu. DATE OF OPERATION   |                                      | 21fv. DATE OF INJURY  |                                   |
|  |   | 21fw. DATE OF OPERATION   |                                      | 21fx. DATE OF INJURY  |                                   |
|  |   | 21fy. DATE OF OPERATION   |                                      | 21fz. DATE OF INJURY  |                                   |
|  |   | 21ga. DATE OF OPERATION   |                                      | 21gb. DATE OF INJURY  |                                   |
|  |   | 21gc. DATE OF OPERATION   |                                      | 21gd. DATE OF INJURY  |                                   |
|  |   | 21ge. DATE OF OPERATION   |                                      | 21gf. DATE OF INJURY  |                                   |
|  |   | 21gg. DATE OF OPERATION   |                                      | 21gh. DATE OF INJURY  |                                   |
|  |   | 21gi. DATE OF OPERATION   |                                      | 21gj. DATE OF INJURY  |                                   |
|  |   | 21gk. DATE OF OPERATION   |                                      | 21gl. DATE OF INJURY  |                                   |
|  |   | 21gm. DATE OF OPERATION   |                                      | 21gn. DATE OF INJURY  |                                   |
|  |   | 21go. DATE OF OPERATION   |                                      | 21gp. DATE OF INJURY  |                                   |
|  |   | 21gq. DATE OF OPERATION   |                                      | 21gr. DATE OF INJURY  |                                   |
|  |   | 21gs. DATE OF OPERATION   |                                      | 21gt. DATE OF INJURY  |                                   |
|  |   | 21gu. DATE OF OPERATION   |                                      | 21gv. DATE OF INJURY  |                                   |
|  |   | 21gw. DATE OF OPERATION   |                                      | 21gx. DATE OF INJURY  |                                   |
|  |   | 21gy. DATE OF OPERATION   |                                      | 21gz. DATE OF INJURY  |                                   |
|  |   | 21ha. DATE OF OPERATION   |                                      | 21hb. DATE OF INJURY  |                                   |
|  |   | 21hc. DATE OF OPERATION   |                                      | 21hd. DATE OF INJURY  |                                   |
|  |   | 21he. DATE OF OPERATION   |                                      | 21hf. DATE OF INJURY  |                                   |
|  |   | 21hg. DATE OF OPERATION   |                                      | 21hh. DATE OF INJURY  |                                   |
|  |   | 21hi. DATE OF OPERATION   |                                      | 21hj. DATE OF INJURY  |                                   |
|  |   | 21hk. DATE OF OPERATION   |                                      | 21hl. DATE OF INJURY  |                                   |
|  |   | 21hm. DATE OF OPERATION   |                                      | 21hn. DATE OF INJURY  |                                   |
|  |   | 21ho. DATE OF OPERATION   |                                      | 21hp. DATE OF INJURY  |                                   |
|  |   | 21hq. DATE OF OPERATION   |                                      | 21hr. DATE OF INJURY  |                                   |
|  |   | 21hs. DATE OF OPERATION   |                                      | 21ht. DATE OF INJURY  |                                   |
|  |   | 21hu. DATE OF OPERATION   |                                      | 21hv. DATE OF INJURY  |                                   |
|  |   | 21hw. DATE OF OPERATION   |                                      | 21hx. DATE OF INJURY  |                                   |
|  |   | 21hy. DATE OF OPERATION   |                                      | 21hz. DATE OF INJURY  |                                   |
|  |   | 21ia. DATE OF OPERATION   |                                      | 21ib. DATE OF INJURY  |                                   |
|  |   | 21ic. DATE OF OPERATION   |                                      | 21id. DATE OF INJURY  |                                   |
|  |   | 21ie. DATE OF OPERATION   |                                      | 21if. DATE OF INJURY  |                                   |
|  |   | 21ig. DATE OF OPERATION   |                                      | 21ih. DATE OF INJURY  |                                   |
|  |   | 21ii. DATE OF OPERATION   |                                      | 21ij. DATE OF INJURY  |                                   |
|  |   | 21ik. DATE OF OPERATION   |                                      | 21il. DATE OF INJURY  |                                   |
|  |   | 21im. DATE OF OPERATION   |                                      | 21in. DATE OF INJURY  |                                   |
|  |   | 21io. DATE OF OPERATION   |                                      | 21ip. DATE OF INJURY  |                                   |
|  |   | 21iq. DATE OF OPERATION   |                                      | 21ir. DATE OF INJURY  |                                   |
|  |   | 21is. DATE OF OPERATION   |                                      | 21it. DATE OF INJURY  |                                   |
|  |   | 21iu. DATE OF OPERATION   |                                      | 21iv. DATE OF INJURY  |                                   |
|  |   | 21iw. DATE OF OPERATION   |                                      | 21ix. DATE OF INJURY  |                                   |
|  |   | 21iy. DATE OF OPERATION   |                                      | 21iz. DATE OF INJURY  |                                   |
|  |   | 21ja. DATE OF OPERATION   |                                      | 21jb. DATE OF INJURY  |                                   |
|  |   | 21jc. DATE OF OPERATION   |                                      | 21jd. DATE OF INJURY  |                                   |
|  |   | 21je. DATE OF OPERATION   |                                      | 21jf. DATE OF INJURY  |                                   |
|  |   | 21jg. DATE OF OPERATION   |                                      | 21jh. DATE OF INJURY  |                                   |
|  |   | 21ji. DATE OF OPERATION   |                                      | 21jj. DATE OF INJURY  |                                   |
|  |   | 21jk. DATE OF OPERATION   |                                      | 21jl. DATE OF INJURY  |                                   |
|  |   | 21jm. DATE OF OPERATION   |                                      | 21jn. DATE OF INJURY  |                                   |
|  |   | 21jo. DATE OF OPERATION   |                                      | 21jp. DATE OF INJURY  |                                   |
|  |   | 21jq. DATE OF OPERATION   |                                      | 21jr. DATE OF INJURY  |                                   |
|  |   | 21js. DATE OF OPERATION   |                                      | 21jt. DATE OF INJURY  |                                   |
|  |   | 21ju. DATE OF OPERATION   |                                      | 21jv. DATE OF INJURY  |                                   |
|  |   | 21jw. DATE OF OPERATION   |                                      | 21jx. DATE OF INJURY  |                                   |
|  |   | 21jy. DATE OF OPERATION   |                                      | 21jz. DATE OF INJURY  |                                   |
|  |   | 21ka. DATE OF OPERATION   |                                      | 21kb. DATE OF INJURY  |                                   |
|  |   | 21kc. DATE OF OPERATION   |                                      | 21kd. DATE OF INJURY  |                                   |
|  |   | 21ke. DATE OF OPERATION   |                                      | 21kf. DATE OF INJURY  |                                   |
|  |   | 21kg. DATE OF OPERATION   |                                      | 21kh. DATE OF INJURY  |                                   |
|  |   | 21ki. DATE OF OPERATION   |                                      | 21kj. DATE OF INJURY  |                                   |
|  |   | 21kk. DATE OF OPERATION   |                                      | 21kl. DATE OF INJURY  |                                   |
|  |   | 21km. DATE OF OPERATION   |                                      | 21kn. DATE OF INJURY  |                                   |
|  |   | 21ko. DATE OF OPERATION   |                                      | 21kp. DATE OF INJURY  |                                   |
|  |   | 21kq. DATE OF OPERATION   |                                      | 21kr. DATE OF INJURY  |                                   |
|  |   | 21ks. DATE OF OPERATION   |                                      | 21kt. DATE OF INJURY  |                                   |
|  |   | 21ku. DATE OF OPERATION   |                                      | 21kv. DATE OF INJURY  |                                   |
|  |   | 21kw. DATE OF OPERATION   |                                      | 21kx. DATE OF INJURY  |                                   |
|  |   | 21ky. DATE OF OPERATION   |                                      | 21kz. DATE OF INJURY  |                                   |
|  |   | 21la. DATE OF OPERATION   |                                      | 21lb. DATE OF INJURY  |                                   |
|  |   | 21lc. DATE OF OPERATION   |                                      | 21ld. DATE OF INJURY  |                                   |
|  |   | 21le. DATE OF OPERATION   |                                      | 21lf. DATE OF INJURY  |                                   |
|  |   | 21lg. DATE OF OPERATION   |                                      | 21lh. DATE OF INJURY  |                                   |
|  |   | 21li. DATE OF OPERATION   |                                      | 21lj. DATE OF INJURY  |                                   |
|  |   | 21lk. DATE OF OPERATION   |                                      | 21ll. DATE OF INJURY  |                                   |
|  |   | 21lm. DATE OF OPERATION   |                                      | 21ln. DATE OF INJURY  |                                   |
|  |   | 21lo. DATE OF OPERATION   |                                      | 21lp. DATE OF INJURY  |                                   |
|  |   | 21lq. DATE OF OPERATION   |                                      | 21lr. DATE OF INJURY  |                                   |
|  |   | 21ls. DATE OF OPERATION   |                                      | 21lt. DATE OF INJURY  |                                   |
|  |   | 21lu. DATE OF OPERATION   |                                      | 21lv. DATE OF INJURY  |                                   |
|  |   | 21lw. DATE OF OPERATION   |                                      | 21lx. DATE OF INJURY  |                                   |
|  |   | 21ly. DATE OF OPERATION   |                                      | 21lz. DATE OF INJURY  |                                   |
|  |   | 21ma. DATE OF OPERATION   |                                      | 21mb. DATE OF INJURY  |                                   |
|  |   | 21mc. DATE OF OPERATION   |                                      | 21md. DATE OF INJURY  |                                   |
|  |   | 21me. DATE OF OPERATION   |                                      | 21mf. DATE OF INJURY  |                                   |
|  |   | 21mg. DATE OF OPERATION   |                                      | 21mh. DATE OF INJURY  |                                   |
|  |   | 21mi. DATE OF OPERATION   |                                      | 21mj. DATE OF INJURY  |                                   |
|  |   | 21mk. DATE OF OPERATION   |                                      | 21ml. DATE OF INJURY  |                                   |
|  |   | 21mm. DATE OF OPERATION   |                                      | 21mn. DATE OF INJURY  |                                   |
|  |   | 21mo. DATE OF OPERATION   |                                      | 21mp. DATE OF INJURY  |                                   |
|  |   | 21mq. DATE OF OPERATION   |                                      | 21mr. DATE OF INJURY  |                                   |
|  |   | 21ms. DATE OF OPERATION   |                                      | 21mt. DATE OF INJURY  |                                   |
|  |   | 21mu. DATE OF OPERATION   |                                      | 21mv. DATE OF INJURY  |                                   |
|  |   | 21mw. DATE OF OPERATION   |                                      | 21mx. DATE OF INJURY  |                                   |
|  |   | 21my. DATE OF OPERATION   |                                      | 21mz. DATE OF INJURY  |                                   |
|  |   | 21na. DATE OF OPERATION   |                                      | 21nb. DATE OF INJURY  |                                   |
|  |   | 21nc. DATE OF OPERATION   |                                      | 21nd. DATE OF INJURY  |                                   |
|  |   | 21ne. DATE OF OPERATION   |                                      | 21nf. DATE OF INJURY  |                                   |
|  |   | 21ng. DATE OF OPERATION   |                                      | 21nh. DATE OF INJURY  |                                   |
|  |   | 21ni. DATE OF OPERATION   |                                      | 21nj. DATE OF INJURY  |                                   |
|  |   | 21nk. DATE OF OPERATION   |                                      | 21nl. DATE OF INJURY  |                                   |
|  |   | 21nm. DATE OF OPERATION   |                                      | 21nn. DATE OF INJURY  |                                   |
|  |   | 21no. DATE OF OPERATION   |                                      | 21np. DATE OF INJURY  |                                   |
|  |   | 21nq. DATE OF OPERATION   |                                      | 21nr. DATE OF INJURY  |                                   |
|  |   | 21ns. DATE OF OPERATION   |                                      | 21nt. DATE OF INJURY  |                                   |
|  |   | 21nu. DATE OF OPERATION   |                                      | 21nv. DATE OF INJURY  |                                   |
|  |   | 21nw. DATE OF OPERATION   |                                      | 21nx. DATE OF INJURY  |                                   |
|  |   | 21ny. DATE OF OPERATION   |                                      | 21nz. DATE OF INJURY  |                                   |
|  |   | 21oa. DATE OF OPERATION   |                                      | 21ob. DATE OF INJURY  |                                   |
|  |   | 21oc. DATE OF OPERATION   |                                      | 21od. DATE OF INJURY  |                                   |
|  |   | 21oe. DATE OF OPERATION   |                                      | 21of. DATE OF INJURY  |                                   |
|  |   | 21og. DATE OF OPERATION   |                                      | 21oh. DATE OF INJURY  |                                   |
|  |   | 21oi. DATE OF OPERATION   |                                      | 21oj. DATE OF INJURY  |                                   |
|  |   | 21ok. DATE OF OPERATION   |                                      | 21ol. DATE OF INJURY  |                                   |
|  |   | 21om. DATE OF OPERATION   |                                      | 21on. DATE OF INJURY  |                                   |
|  |   | 21oo. DATE OF OPERATION   |                                      | 21op. DATE OF INJURY  |                                   |
|  |   | 21oq. DATE OF OPERATION   |                                      | 21or. DATE OF INJURY  |                                   |
|  |   | 21os. DATE OF OPERATION   |                                      | 21ot. DATE OF INJURY  |                                   |
|  |   | 21ou. DATE OF OPERATION   |                                      | 21ov. DATE OF INJURY  |                                   |
|  |   | 21ow. DATE OF OPERATION   |                                      | 21ox. DATE OF INJURY  |                                   |
|  |   | 21oy. DATE OF OPERATION   |                                      | 21oz. DATE OF INJURY  |                                   |
|  |   | 21pa. DATE OF OPERATION   |                                      | 21pb. DATE OF INJURY  |                                   |
|  |   | 21pc. DATE OF OPERATION   |                                      | 21pd. DATE OF INJURY  |                                   |
|  |   | 21pe. DATE OF OPERATION   |                                      | 21pf. DATE OF INJURY  |                                   |
|  |   | 21pg. DATE OF OPERATION   |                                      | 21ph. DATE OF INJURY  |                                   |
|  |   | 21pi. DATE OF OPERATION   |                                      | 21pj. DATE OF INJURY  |                                   |
|  |   | 21pk. DATE OF OPERATION   |                                      | 21pl. DATE OF INJURY  |                                   |
|  |   | 21pm. DATE OF OPERATION   |                                      | 21pn. DATE OF INJURY  |                                   |
|  |   | 21po. DATE OF OPERATION   |                                      | 21pp. DATE OF INJURY  |                                   |
|  |   | 21pq. DATE OF OPERATION   |                                      | 21pr. DATE OF INJURY  |                                   |
|  |   | 21ps. DATE OF OPERATION   |                                      |   |                                   |

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JAN 20 1985

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene arie: to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 8 2 0 1 2 8 8   |  |  |  |
|--|--|--|--|---|--|--|--|
| FOR<br>1. STATE<br>REGISTRAR   |  |  |  | CERTIFICATE OF DEATH  |  |  |  |
| 1. LAST NAME<br><i>Shimiko</i>   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>01 17 82</i>   |  |  |  |
| 3. SEX<br><i>F</i>   |  |  |  | 2b. HOUR<br><i>2 P M</i>  |  |  |  |
| 4. RACE<br><i>BLACK</i>  |  |  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>01 16 82</i>  |  |  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>0 YRS 0 1 20</i>   |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>MARYLAND</i>   |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Towson CITY</i>   |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>None</i>  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><i>Univ. md Hosp S. Greene ST</i>  |  |  |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><i>None</i>   |  |  |  | 13a. STREET ADDRESS<br><i>614 Westover Drive</i>  |  |  |  |
| 13b. STATE<br><i>md</i>  |  |  |  | 13c. CITY OR TOWN<br><i>Salisbury</i>   |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>DERRICK</i>  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>KAREN MILLS</i>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><i>NA</i>   |  |  |  | 16b. SOCIAL SECURITY NO.<br><i>None</i>   |  |  |  |
| 17. INFORMANT<br><i>KAREN MILLS</i>  |  |  |  | ADDRESS<br><i>SAME AS ABOVE</i>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>CARDIORESPIRATORY ARREST</i><br><i>7670</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>ACIDOSIS HYPOXIA</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>Intraventricular Hemorrhage.</i>  |  |  |  |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>PREMATURITY</i>   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><i>1/16</i>  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>  |  |  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  | 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  |  |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1/16</i> , 19 <i>82</i> , to <i>1/17</i> , 19 <i>82</i> , that (I) (we) lost<br>saw the deceased alive on <i>1/17</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><i>J. Mancuso MD</i>   |  |  |  | 22c. DATE SIGNED<br><i>1/17/82</i>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>MANCUSO</i>  |  |  |  | 22e. ADDRESS<br><i>22 S. Greene ST Balt Md</i>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>BURIAL</i>   |  |  |  | 23b. DATE<br><i>1/26/82</i>   |  |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><i>Green Acres Mem.</i>  |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><i>Salisbury Wicomico Md.</i>  |  |  |  |
| 24. FUNERAL DIRECTOR<br><i>Jolley Memorial Chapel</i>  |  |  |  | 25. DATE REC'D. BY REGISTRAR<br><i>FEB 3 1982</i>   |  |  |  |

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2025 COLLECTION - 1888



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8-2 01289

|  |  |  |   |  |                                   |
|--|--|--|---|--|-----------------------------------|
| 1. FOR STATE REGISTRAR   |  | 20. DATE OF DEATH  |   | 2b. HOUR   |                                   |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | 20. DATE OF DEATH  |   | 2b. HOUR   |                                   |
| ELISABETH P. MILLSPAUGH  |  | 1 2 82   |   | 2 20 AM  |                                   |
| 3. SEX   | 4. RACE  | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY)                               | 8. YRS.  |                                   |
| Female   | White  | Feb. 4 1895  | 86  |  |                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                          |  |                                   |
| Ohio   | U.S.A.   |  | BALTIMORE CITY MD.  |  |                                   |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY |
| BALTIMORE  | UNION MEMORIAL HOSPITAL  |  | Homemaker   |  | Own Home                          |
| 13a. STATE   |  | 13b. COUNTY  | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?   | 13e. STREET ADDRESS               |
| Md.  |  |  | Balto.  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            | 3900 N. Charles St.               |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |   |  |                                   |
| FIRST MIDDLE LAST  |  | FIRST MIDDLE LAST  |   |  |                                   |
| Howard C. Park   |  | Martha Sells   |   |  |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT ADDRESS  |                                   |
| No   |  | 214-44-9901  |   | Martin L. Millspaugh Jr. Balto., Md.   |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |   |  |                                   |
| PART 1. DEATH WAS CAUSED BY:   |  |  |   |  |                                   |
| IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 74 hrs  |  |  |   |  |                                   |
| 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD</u>   |  |  |   |  |                                   |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |   |  |                                   |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |   |  |                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |   |  |                                   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?  |                                   |
|  |  |  |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |                                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                   |
|  |  | P.M. 19  |   |  |                                   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |                                   |
|  |  |  |   |  |                                   |
| 22a. I certify that (this hospital) attended the deceased from <u>1/1/82</u> , 19 <u>82</u> , to <u>1/2</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>1/2</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. |  |  |   |  |                                   |
| 22b. SIGNATURE   |  | DEGREE   |   | 22c. DATE SIGNED   |                                   |
| <u>David C. Allen</u>  |  | MD   |   | 1/2/82   |                                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |   |  |                                   |
| DAVID C. ALLEN   |  | UNION MEMORIAL HOSPITAL  |   |  |                                   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY   |                                   |
| Cremation  |  | 1-3-82   |   | Security Process   |                                   |
| 24. FUNERAL DIRECTOR NAME  |  | 24b. ADDRESS   |   | 25a. DATE REC'D. BY REGISTRAR  |                                   |
| H. W. Jenkins & Sons Co., Balto., Md.  |  | 4905 York Rd.  |   | JAN 4 1982   |                                   |
|  |  |  |   | 25b. REGISTRAR'S SIGNATURE   |                                   |
|  |  |  |   | <u>James J. Norton</u>   |                                   |

WILLIAM

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BALTIMORE CITY

UNION MEDICAL HOSPITAL

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UNION MEDICAL HOSPITAL

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This page must be taken to the funeral home to be filed in the records of the funeral home. The funeral home must be notified of the death of the deceased.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DDMH-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 2 9 0

|   |  |   |  |
|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO.  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>Leonard</b>  |  | 2. DATE OF DEATH MONTH DAY YEAR<br><b>Jan 12, 1982</b>  |  |
| 3. SEX<br><b>MALE</b>   |  | 2b. HOUR<br><b>5:10P</b>  |  |
| 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br><b>JULY 12, 1932</b>  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>49</b>  |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NEW YORK</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>The Johns Hopkins Hospital</b> |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SALESMAN</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>CEMETERY</b>  |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  |
| 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 13e. STREET ADDRESS<br><b>APT. C 3907 FORDLEIGH RD. #21215</b>  |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>PHILIP MINKOWITZ</b>  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>SHIRLEY KAPLAN</b>   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>YES</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>KOREAN-ARMY</b>  |  |
| 17. INFORMANT<br><b>MRS. MIRIAM MINKOWITZ</b>   |  | ADDRESS<br><b>3907 FORDLEIGH RD., APT. C #21215</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>stroke</b><br>1629<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>metastatic large cell lung cancer</b><br>(c) <b>probable pulmonary embolus</b>         |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6 hrs</b><br><b>1 1/2 hrs</b>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  | 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                   |  |
| 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (this hospital) attended the deceased from <b>9-21-</b> 19 <b>82</b> , to <b>1-12-</b> 19 <b>82</b> , that I (we) last saw the deceased alive on <b>1-12-</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |
| 22b. SIGNATURE<br><b>Constance Griffin MD</b>   |  | DEGREE<br><b>MD</b>   |  |
| 22c. DATE SIGNED<br><b>1-12-82</b>  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CONSTANCE GRIFFIN MD</b>  |  |
| 22e. ADDRESS<br><b>JOHNS HOPKINS ONCOLOGY CENTER</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>REMOVAL/BURIAL</b>  |  | 23b. DATE<br><b>JAN. 14, 1982</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>FLORAL PARK</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY<br><b>DEANS NEW JERSEY NEW YORK</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b><br>ADDRESS<br><b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 20 1982</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Jan Nathan</b>   |  |   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 2 9 1

REG. NO.

|   |  |  |  |   |  |  |  |  |  |
|---|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>DANIEL J. MINNICK</b>  |  |  | 2a. DATE OF DEATH<br>MONTH <b>01</b> DAY <b>07</b> YEAR <b>82</b>      |   |  | 2b. HOUR<br><b>5-18</b> A M  |  |  |  |
| 3. SEX<br><b>M</b>  |  | 4. RACE<br><b>W</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>05</b> DAY <b>02</b> YEAR <b>02</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> YRS.  |  |  |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO CITY</b> MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO CITY</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>CITY HOSP.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>TAVERN OWNER</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD.</b>   |  | 13b. COUNTY <b>BALTO</b>   |  | 13c. CITY OR TOWN <b>DUNDALK</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>7050 SOLLERS PT RD.</b>  |  |
| 14. FATHER'S NAME<br>FIRST <b>DANIEL</b> MIDDLE <b>MINNICK</b> LAST <b>MINNICK</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>MARY</b> MIDDLE <b>SANDERS</b> LAST <b>SANDERS</b>   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>215-05-7603</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>DOROTHY MINNICK 7050 SOLLERS PT RD</b>   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY ARREST</b><br><b>4273</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)  |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET<br>CITY OR TOWN<br>COUNTY<br>STATE                     |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12-30</b> , 19 <b>81</b> , to <b>1-7</b> , 19 <b>82</b> , that (I) (we) lost<br>saw the deceased alive on <b>1-7</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did not) view the body after death.             |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Stephen J. Osmanski</b>  |  |  | DEGREE<br><b>MD</b>  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1-7-82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>OSMANSKI, MD</b>  |  |  | 22e. ADDRESS<br><b>BALTO CITY HOSP</b>                                 |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>BURIAL</b>  |  |  | 23b. DATE<br><b>1-9-82</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>SACRED HEART, F.MARY</b>              |  | 23d. LOCATION<br>CITY OR TOWN <b>DUNDALK</b> COUNTY <b>BALTO</b> STATE <b>MD</b> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>CONNELLY FUNERAL HOME</b>  |  |  | ADDRESS<br><b>7110 SOLLERS PT RD.</b>                                  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 8 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Anna J. [Signature]</i>   |  |



*[Faint, mostly illegible handwritten text on lined paper. The text appears to be a list or series of entries, possibly related to a collection or inventory. Some words are difficult to decipher due to fading and bleed-through.]*

*[Faint, mostly illegible handwritten text at the bottom of the page, possibly a signature or date.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |   | 8 2 0 1 2 9 2   |                      |  |  |
|---|--|---|---|---|----------------------|--|--|
| 1. FOR STATE REGISTRAR  |  |   |   | REG. NO.  |                      |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>ROSA M. MINTON   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>01 23 82 |   | 2b. HOUR<br>10:00 AM |  |  |
| 3. SEX<br>F   |  | 4. RACE<br>W  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>03 31 89  |                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br>82<br># UNDER 1 YEAR<br>MONTHS DAYS<br># UNDER 24 HRS<br>HOURS MIN.                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>TENN   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTO. CITY MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTO  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>BALTO. CITY HOSP |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HSWR  |                      | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>MD.   |  |   |   | 13b. COUNTY<br>BALTO  |                      | 13c. CITY OR TOWN<br>DUNDALK   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>ELLIOTT   |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>UNK  |                      |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br>412 46 7936   |   | 17. INFORMANT<br>RALPH MINTON   |                      | ADDRESS<br>ABOVE   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u><br>3369<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |   |   |                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>s/p diffuse cerebral anoxia 7 cardiac arrest 1-08-82  |  |   |   |   |                      |  |  |
| 19a. DATE OF OPERATION<br>12-26-81  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Thoracic spinal cord compression  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                      |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                      |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-26-81, 19____, to 01-23-81, 19____, that (I) (we) lost saw the deceased alive on 01-22-81, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                     |  |   |   |   |                      |  |  |
| 22b. SIGNATURE<br>Jules C Monier, MD  |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |                      | 22c. DATE SIGNED<br>01-23-82   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Jules C. Monier, MD.   |  |   |   | 22e. ADDRESS<br>Baltimore City Hospitals  |                      |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  | 23b. DATE<br>1/26/82  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>BELAIR CEM  |                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BELAIR   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>J-E CONNELLY  |  |   |   | ADDRESS<br>300 MACE   |                      | 25a. DATE REC'D BY REGISTRAR<br>JAN 29 1982  |  |
|   |  |   |   | 25b. REGISTRAR'S SIGNATURE<br>James D. [Signature]  |                      |  |  |



1. NAME (Last, first, middle initial)  
2. GRADE OR RATE  
3. BRANCH  
4. ORGANIZATION  
5. ADDRESS (Street, city, state, zip)

6. PHONE NUMBER (Area code, number)  
7. SOCIAL SECURITY NUMBER

8. DATE OF BIRTH (Month, day, year)  
9. DATE OF ENTRY INTO SERVICE (Month, day, year)  
10. DATE OF EXPIRATION OF SERVICE (Month, day, year)  
11. DATE OF LAST PROMOTION (Month, day, year)  
12. DATE OF LAST ASSIGNMENT (Month, day, year)

13. DATE OF LAST EVALUATION (Month, day, year)  
14. DATE OF LAST INSPECTION (Month, day, year)  
15. DATE OF LAST REVIEW (Month, day, year)

16. DATE OF LAST PROMOTION (Month, day, year)  
17. DATE OF LAST ASSIGNMENT (Month, day, year)  
18. DATE OF LAST EVALUATION (Month, day, year)

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 2 9 3

REG. NO.

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <u>SOL JERRY J. MINTZ</u>   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR <u>Jan. 4. 1982</u> 2b. HOUR <u>10<sup>26</sup> AM</u>  |  |   |  |
| 3. SEX <u>M ALE</u>   |  | 4. RACE <u>CAUCASIAN</u>  |  | 5. DATE OF BIRTH MONTH DAY YEAR <u>May 24 1914</u>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <u>67</u> <del>68</del> <del>69</del> <del>70</del> <del>71</del> <del>72</del> <del>73</del> <del>74</del> <del>75</del> <del>76</del> <del>77</del> <del>78</del> <del>79</del> <del>80</del> <del>81</del> <del>82</del> <del>83</del> <del>84</del> <del>85</del> <del>86</del> <del>87</del> <del>88</del> <del>89</del> <del>90</del> <del>91</del> <del>92</del> <del>93</del> <del>94</del> <del>95</del> <del>96</del> <del>97</del> <del>98</del> <del>99</del> YRS |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>POLAND</u>   |  | 7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>City</u> MD.  |  |
| 10. CITY OR TOWN OF DEATH <u>Baltimore</u>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Sinai Hospital of Baltimore</u> |  |  |  | 12a. USUAL RESIDENCE (IF EMPLOYED, GIVE STREET ADDRESS) <u>Retired</u>  |  |
| 12b. KIND OF BUSINESS OR INDUSTRY <u>FOOD MARKET</u>  |  | 13a. STATE <u>MARYLAND</u>  |  | 13b. COUNTY <u>BALTIMORE</u>   |  | 13c. CITY OR TOWN <u>BALTIMORE</u>  |  |
| 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS <u>5411 Gist Avenue 21215</u>   |  | 14. FATHER'S NAME FIRST MIDDLE LAST <u>MAX MINTZ</u>   |  |   |  |
| 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>MARTHA UNKNOWN</u>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>YES</u>  |  | 16b. SOCIAL SECURITY NO. <u>286-10-0207</u>  |  | 17. INFORMANT <u>MRS. JENNIE MINTZ</u>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>4140 Atherosclerotic Heart disease</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u>  |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____                   |  |   |  |
| 19a. DATE OF OPERATION _____  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED _____  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR _____ P.M. _____ 19 _____  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2) _____   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) _____   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE _____   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 2</u> , 19 <u>82</u> , to <u>Jan 4</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>Jan 4</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |   |  |
| 22b. SIGNATURE <u>Ming Chang</u>  |  | DEGREE _____  |  | 22c. DATE SIGNED <u>Jan 4, 1982</u>  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>MING CHANG</u>   |  |
| 22e. ADDRESS <u>Sinai Hospital of Baltimore</u>   |  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>   |  | 23b. DATE <u>JAN. 5, 1982</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY <u>MOGAN ABRAHAM</u>   |  |
| 23d. LOCATION <u>ROSEDALE BALTO. MD</u>   |  | 24. FUNERAL DIRECTOR NAME <u>SOL LEVINSON &amp; BROS., INC.</u>   |  | 25a. DATE REC'D. BY REGISTRAR <u>JAN 7 1982</u>  |  | 25b. REGISTRAR'S SIGNATURE <u>James Van Winkle</u>  |  |
| 6010 REISTERSTOWN RD. BALTO., MD 21215  |  |   |  |  |  |   |  |

under the parents 2831 P H01



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH-17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |                  |                 |  |  |               |   |   |                  |  |  |   |                                       |                           |               |  |  |   |                   |  |               |  |  |                        |  |  |
|--|--|------------------|-----------------|--|--|---------------|---|---|------------------|--|--|---|---------------------------------------|---------------------------|---------------|--|--|---|-------------------|--|---------------|--|--|------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |                  | FIRST<br>Amanda |  |  | MIDDLE<br>Rae |   |   | LAST<br>Miskimon |  |  | 2a. DATE KNOWN<br>OF DEATH<br>ESTI-<br>MATED  |                                       |                           | MONTH<br>XX 1 |  |  | DAY<br>24   |                   |  | YEAR<br>19 82 |  |  | 2b. HOUR<br>M<br>7:32A |  |  |
| 3. SEX<br>female   |  | 4. RACE<br>white |                 | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12-21-1981   |  |               | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br>1 5 |   |                  | IF UNDER 1 YR.<br>MONTHS DAYS<br>1 5                       |  |   | IF UNDER 24 HRS.<br>HOURS MIN.<br>1 5 |                           |               | 7c. DATE<br>PRONOUNCED<br>DEAD<br>MONTH DAY YEAR<br>1 25 19 82 |  |   | 2d. HOUR<br>7:32A |  |               |  |  |                        |  |  |
| 7b. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)<br>Balto.   |  |                  |                 | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  |               |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |                                       |                           |               |  |  |   |                   |  |               |  |  |                        |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |                  |                 | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>2934 E. Baltimore Street |  |               |   |   |                  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)<br>-                           |                                       |                           |               | 12b. KIND OF BUSINESS<br>OR INDUSTRY<br>-                      |  |   |                   |  |               |  |  |                        |  |  |
| 13a. STATE<br>Md.  |  |                  |                 | 13b. COUNTY<br>BALTO.  |  |               |   | 13c. CITY OR TOWN<br>Balto.   |                  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                       |                           |               | 13e. STREET ADDRESS<br>2934 E. Baltimore Street                |  |   |                   |  |               |  |  |                        |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Matthew Miskimon   |  |                  |                 |  |  |               |   |   |                  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Lori Ward |  |   |                                       |                           |               |  |  |   |                   |  |               |  |  |                        |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>no  |  |                  |                 | (IF YES, GIVE WAR OR DATES)  |  |               |   | 16b. SOCIAL SECURITY NO.<br>none  |                  |  |  | 17. INFORMANT<br>Matthew Miskimon   |                                       |                           |               | ADDRESS<br>21224<br>2934 E. Baltimore                          |  |   |                   |  |               |  |  |                        |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Sudden Infant Death Syndrome<br>7980<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                       |  |                  |                 |  |  |               |   |   |                  |  |  |   |                                       |                           |               |  |  |   |                   |  |               |  |  |                        |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                  |                 |  |  |               |   |   |                  |  |  |   |                                       |                           |               |  |  |   |                   |  |               |  |  |                        |  |  |
| 19a. DATE OF OPERATION   |  |                  |                 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |               |   |   |                  |  |  |   |                                       |                           |               |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                   |  |               |  |  |                        |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                  |                 | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |               |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>XXX  |                  |  |  |   |                                       |                           |               |  |  |   |                   |  |               |  |  |                        |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |                  |                 | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)   |  |               |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                  |  |  |   |                                       |                           |               |  |  |   |                   |  |               |  |  |                        |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                  |                 |  |  |               |   |   |                  |  |  |   |                                       |                           |               |  |  |   |                   |  |               |  |  |                        |  |  |
| ACTUAL<br>SIGNATURE<br>Virginia L. Dolan   |  |                  |                 | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER   |  |               |   |   |                  |  |  |   |                                       | DATE<br>SIGNED<br>1/25/82 |               |  |  |   |                   |  |               |  |  |                        |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Virginia L. Dolan, M.D.  |  |                  |                 | ADDRESS<br>111 Penn Street, Balto., MD 21201   |  |               |   |   |                  |  |  |   |                                       |                           |               |  |  |   |                   |  |               |  |  |                        |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |                  |                 | 23b. DATE<br>1-27-82   |  |               |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Meadowridge Mem. Pk.  |                  |  |  | 23d. LOCATION<br>CITY OR TOWN<br>Md.  |                                       |                           |               | COUNTY STATE   |  |   |                   |  |               |  |  |                        |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Schimunek Funeral Home Inc.<br>3331 Brenns Lane 21213  |  |                  |                 |  |  |               |   |   |                  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 26 1982               |  |   |                                       |                           |               |  |  | 25b. REGISTRAR'S SIGNATURE<br>James J. Nathan                                       |                   |  |               |  |  |                        |  |  |

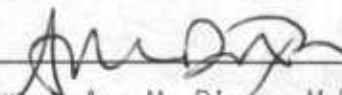

RECEIVED  
ST. PAUL, MINN. FEBRUARY 1908

200- COLONIAL

at 200- Colonial, 1908

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 7 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                      |   |   |  |   |  |  |   | REG. NO. 2 0 1 2 9 5  |  |                                   |  |
|--|--|----------------------|---|---|--|---|--|--|---|---|--|-----------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ROBERT Lee MITCHELL</b>   |  |                      |   |   |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> EST. <input type="checkbox"/> MATED <input type="checkbox"/>                                    |  | MONTH DAY YEAR <b>1 2 19 82</b>  |   | 2b. HOUR <b>12:10</b>   |  |                                   |  |
| 3. SEX <b>male</b>   |  | 4. RACE <b>negro</b> |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>8 26 39</b>                         |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY YRS. <b>42</b>   |  | IF UNDER 1 YR. MONTHS DAYS   |   | IF UNDER 24 HRS. HOURS MIN.   |  |                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ga.</b>   |  |                      | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>            |   |  |                                   |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |  |                      | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>street - 1034 N. Patterson Pk. Ave.</b> |   |  |   |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)         |   |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| 13a. STATE <b>Md.</b>  |  | 13b. COUNTY          |   | 13c. CITY OR TOWN <b>Balto.</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS <b>2711 Oswego Ave.</b>  |   |   |  |                                   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>Johnnie Mitchell</b>   |  |                      |   |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Willie Davis</b>   |  |  |   |   |  |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>Yes</b>   |  |                      |   | (IF YES, GIVE WAR OR DATES) <b>Vietnam</b>                                |  | 16b. SOCIAL SECURITY NO. <b>257-62-7679</b>   |  | 17. INFORMANT ADDRESS<br><b>Paula R. Thomas 2711 Oswego Ave.</b>   |   |   |  |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Gunshot wound of chest (rifle)</b><br>9652<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF   |  |                      |   |   |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |                                   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |  |                      |   |   |  |   |  |  |   |   |  |                                   |  |
| 19a. DATE OF OPERATION   |  |                      |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                         |  |   |  |  |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                                   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                      |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR <b>11:40 AM 1-2- 1982</b> |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Subject was shot.</b>  |  |  |   |   |  |                                   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>  |  |                      |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>street</b> |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>1034 N. Patterson Pk. Ave., Balto. City Md.</b>   |  |  |   |   |  |                                   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                      |   |   |  |   |  |  |   |   |  |                                   |  |
| ACTUAL SIGNATURE    |  |                      |   | TITLE (SPECIFY) <b>Assistant</b>  |  |   |  | DATE SIGNED <b>1-3-82</b>  |   |   |  |                                   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>  |  |                      |   | ADDRESS <b>111 Penn St.</b>   |  |   |  |  |   |   |  |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  |                      |   | 23b. DATE <b>1/7/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Md. Vet. Cem.</b>   |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Crownsville, Md.</b> |   |  |                                   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm C March F/H 1101 E. North Ave.</b>   |  |                      |   |   |  | 25a. DATE REC'D. BY REGISTRAR <b>JAN 5 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE  |   |   |  |                                   |  |

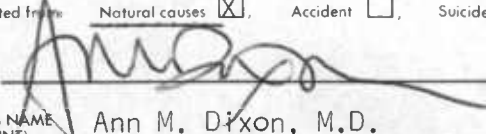
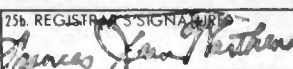


(-3)

FOR COLUMBIA  
AND  
WIND

WIND 2005 2005 2005

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE CHIEF CLERK. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 5 THROUGH 8 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |  |  | REG. NO. 3201296   |  |
|--|--|--|--|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>EDWARD MOLLOCK   |  |   |  |  |  | 2a. DATE KNOWN OF DEATH ESTI-MATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br>1 1 19 82               |  | 2b. HOUR M<br>M  |  |
| 3. SEX<br>male   |  | 4. RACE<br>negro   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>11 20 26   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br>55   |  | IF UNDER 1 YR. MONTHS DAYS HOURS MIN.  |  | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR<br>1 1 19 82                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                                    |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE RESIDENCE BEFORE ADMISSION)<br>University Hospital (DOA) |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>1347 Ward Street  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Edward Mollock  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Laura West  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br>Yes  |  | 16b. SOCIAL SECURITY NO.<br>WW 11  |  | 17. INFORMANT ADDRESS<br>Margaret Talbot-2000 Odell Ave.  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u><br>4292 } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____   |  |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                     |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |  |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |  |  |   |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE    |  |  |  | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER   |  |  |  | DATE SIGNED 1-2-82   |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.   |  |  |  | ADDRESS 111 Penn St.  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>1-6-82  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Md. Veterans Cem.   |  |  |  | 23d. LOCATION CITY OR TOWN<br>Crownsville  |  | COUNTY STATE<br>Md.  |  |
| 24. FUNERAL DIRECTOR NAME<br>CHAS. A. RICE FSPA 1300 Eutaw Pl.   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 5 1982  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified before burial.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 8 2 0 1 2 9 7   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>WILLIE V. MONTAGUE</b>  |  |   |  | 2a. DATE OF DEATH<br>MONTH <b>1</b> DAY <b>31</b> YEAR <b>82</b>  |  | 2b. HOUR<br><b>11:20 AM</b>  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>BLACK</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>4</b> DAY <b>16</b> YEAR <b>11</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b> YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NORTH CAROLINA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. <b>BALTIMORE CITY OR COUNTY OF DEATH</b><br><b>BALTIMORE, CITY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>VAMC, 3900 LOCH RAVEN BLVD.</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>2742 W. MOSHER ST.</b>   |  |
| 14. FATHER'S NAME<br>FIRST <b>—</b> MIDDLE <b>—</b> LAST <b>—</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Henrietta</b> MIDDLE <b>—</b> LAST <b>Richardson</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(IF YES, GIVE WAR OR DATES)<br><b>YES</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>226 10 5961</b>  |  | 17. INFORMANT ADDRESS<br><b>Richard Curtis 2742 W. Mosher St.</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Sepsis (from GI tract) = hypotension, DIC</b><br><b>0389</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>—</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>—</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <b>—</b>  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>1-18</b> , 19 <b>82</b> , to <b>1-31</b> , 19 <b>82</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>1-31-</b> , 19 <b>82</b> , and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> view the body after death. |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>A. A. Ruiz</b>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>A. A. Ruiz</b>   |  |   |  | 22e. ADDRESS<br><b>3900 LOCH RAVEN BLD. BALTO. MD. 21218</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>2/5/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King Mem. Park</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co. MD</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Wm. C. March F/H</b> ADDRESS <b>1101 E. North Ave.</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>FEB 2 1982</b> 25b. REGISTRAR'S SIGNATURE <b>Thomas J. [Signature]</b>   |  |  |  |



2 copies (from direct) = 1 copy from D.C.

A. A. Davis  
A. A. Davis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 8 2 0 1 2 9 8   |  |  |   |
|---|--|--|--|---|--|--|---|
| 1. FOR STATE REGISTRAR  |  |  |  | REG. NO.  |  |  |   |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Keisho Moody   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>1/4/82  |  |  |   |
| 3. SEX<br>Female  |  | 4. RACE<br>Black   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>10 6 81  |  | 2b. HOUR<br>2:18 PM  |   |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>2 mos  |  | 7. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. IF UNDER 1 YEAR MONTHS DAYS<br>2   |  | 9. IF UNDER 24 HRS. HOURS MIN.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>U of M H |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                                       |  |  |   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>—   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>—  |  |  |   |
| 13a. STATE<br>Md  |  | 13b. COUNTY<br>Baltimore   |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13d. STREET ADDRESS<br>651 Cheraton Rd   |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Elbe Stevenson   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Roxanne Moody                                     |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>—  |  | 17. INFORMANT ADDRESS<br>Dorothy Bulos U of M H   |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Resp & Cardiac Arrest<br>DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Damage (Brain Damage)<br>DUE TO, OR AS A CONSEQUENCE OF (c) Group B Hemolytic Strep Meningitis                  |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>Immed<br>3 min<br>12 days |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: —  |  |  |  |   |  |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>2:18 PM 1 4 1982   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)                  |  |  |   |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/23, 19 81, to 1/4, 19 82, that (I) (we) lost saw the deceased alive on 1/4, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |   |
| 22b. SIGNATURE<br>Dorothy Bulos MD  |  |  |  | 22c. DATE SIGNED<br>1/4/82  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dorothy Bulos MD  |   |
| 22e. ADDRESS<br>Red House Staff U of M H  |  |  |  | 22f. DATE REC'D. BY REGISTRAR<br>JAN 6 1982   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>1/7/82  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cemetery                                       |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Balto. Co. MD   |   |
| 24. FUNERAL DIRECTOR NAME<br>Wm. C. March F/H, Inc.   |  |  |  | 25. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE<br>JAN 6 1982 [Signature]                    |  |  |   |



Section 1

Section 2

Section 3

Section 4

Section 5

Section 6

Section 7

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |   |   |  |   |                                    |  |
|--|--|--|--|---|---|---|--|---|------------------------------------|--|
| FOR<br>1. STATE<br>REGISTRAR   |  |  |  |   | REG. NO.  |   |  |   |                                    |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>MARY MOODY</b>  |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11/12/82</b>  |   |  |   |                                    | 2b. HOUR<br>M<br><b></b>                     |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YR<br><b>8 3 05</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b>                              |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b></b>   |                                    | IF UNDER 24 HRS<br>HOURS MIN.<br><b></b>     |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Raeferd, N. Car.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore CITY</b> MD.         |  |   |                                    |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>501 Dolphin Street</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)          |  | 12b. KIND OF BUSINESS OR INDUSTRY   |                                    |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>501 Dolphin Street</b>   |   |                                    |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>Balto.</b>   |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |   |   |  |   |                                    |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Will Gilchrist</b>  |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Frances Gilchrist</b>                       |   |  |   |                                    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>215 22 3905</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>William Monroe 18 Drawbridge Ct.</b>   |   |   |  |   |                                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Food asphyxiation</b><br><b>4110</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <b>Aortic stenosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <b>Coronary insufficiency</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10-12 yr</b><br><b>10-12 yr</b> |  |  |  |   |   |   |  |   |                                    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>ASCVD</b>  |  |  |  |   |   |   |  |   |                                    |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                    |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)   |   |   |  |   |                                    |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |   |                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/10</b> , 19 <b>79</b> , to <b>1/8</b> , 19 <b>82</b> that (I) (we) last saw the deceased alive on <b>1/8</b> , 19 <b>82</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |  |  |   |   |   |  |   |                                    |  |
| 22b. SIGNATURE<br><b>Amatun M. Naeem</b> MD  |  |  |  |   | DEGREE<br><b>MD</b>   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>1/14/82</b> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>AMATUN M NAEEM</b>   |  |  |  |   | 22e. ADDRESS<br><b>501 Dolphin St Balto MD 21207</b>  |   |  |   |                                    |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>1/16/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cem.</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Glen Burnie MD</b>       |  |   |                                    |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>LEROY O. DYETT 4600 LIBERTY HEIGHTS AVE.</b>  |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 19 1982</b>   |   |  |   |                                    | 25b. SIGNATURE<br><b>Frances Jean Nathan</b> |

SECRET



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 8 2 0 1 3 0 0   |  |  |  |
|--|--|--|--|---|--|--|--|
| FOR<br>STATE<br>REGISTRAR  |  |  |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <u>Irene V. MOONEY</u>   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <u>January 27, 1982</u>   |  | 2b. HOUR<br>M  |  |
| 3. SEX<br><u>Female</u>  |  | 4. RACE<br><u>Caucasian</u>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <u>Dec 5, 1910</u>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>71</u> YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>MD</u>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>Baltimore City</u> MD   |  |
| 10. CITY OR TOWN OF DEATH<br><u>Baltimore</u>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>830 S. Suzanne Ave</u> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>Domestic Home</u>  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br><u>MD</u>  |  | 13b. COUNTY<br><u>Baltimore</u>  |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13d. STREET ADDRESS<br><u>830 S. Suzanne Ave</u>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><u>Henry Tuckhardt</u>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><u>Emma Marks</u>   |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <u>No</u>   |  |  |  |
| 16a. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)  |  | 17. INFORMANT<br><u>John Mooney</u>  |  | 17b. ADDRESS<br><u>830 S. Suzanne Ave</u>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Terminal Abdominal Carcinoma</u><br><u>1952</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>1-2 yrs.</u> |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1-18-82</u> to <u>1-22-82</u> , that (I) (we) lost saw the deceased alive on <u>1-18-82</u> , and that it is (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |
| 22a. SIGNATURE<br><u>Thomas P. Rymer, MD</u>   |  |  |  | DEGREE<br><u>MD</u>   |  | 22c. DATE SIGNED<br><u>1-22-82</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>T. P. N. Rymer</u>   |  |  |  | 22e. ADDRESS<br><u>429 5th Ave St 21231</u>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE OR PRINT)<br><u>Burial</u>  |  | 23b. DATE<br><u>1-26-82</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Sacred Heart</u>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Baltimore Co. Md</u>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>Raymond S. Kopych</u>   |  |  |  | ADDRESS<br><u>2525 E. 1st St.</u>   |  | 25. DATE REC'D. BY REGISTRAR<br><u>JAN 26 1982</u>   |  |
|  |  |  |  | 25a. REGISTRAR'S SIGNATURE<br><u>Thomas J. Rymer</u>  |  |  |  |

General William H. Stewart, Esq.

1885-86

1887-88

1889-90

1891-92

1893-94



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP \_\_\_\_\_  
DHMH - 17  
(VR A15 ME (5))  
15M 2/80

| DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |   |                                   | REG. NO. 8 2 0 1 3 0 1                                      |  |
|--|--|--|--|--|--|---|--|---|-----------------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Alice Alexandrian S. Moore</b>  |  |  |  |  |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>1 30 19 82</b> |  | 7b. HOUR <b>M</b>   |                                   |   |  |
| 3. SEX <b>Female</b>   |  | 4. RACE <b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>4 15 13 66</b>   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <b>19 YRS.</b>   |  | IF UNDER 1 YR. MONTHS DAYS HOURS MIN  |                                   | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR <b>2 1 19 82</b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD.</b>   |  |   |                                   |   |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>301 McMechan</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |   | 12b. KIND OF BUSINESS OR INDUSTRY |   |  |
| 13a. STATE <b>MD</b>   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN <b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>              |  | 13e. STREET ADDRESS <b>301 McMechan St.</b>   |                                   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>William Norton Moore</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Mary Elizabeth Spilman</b>  |  |   |  |   |                                   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>No</b>  |  |  |  | 16b. SOCIAL SECURITY NO. <b>N/A</b>  |  | 17. INFORMANT ADDRESS <b>Daniel Shemer 4101 Lowell Dr.</b>  |  |   |                                   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br><b>429.2</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |  |  |  |  |   |  |   |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I a.  |  |  |  |  |  |   |  |   |                                   |   |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                             |  |   |                                   |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |                                   |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |  |  |  |  |   |  |   |                                   |   |  |
| ACTUAL SIGNATURE <b>Thomas D. Smith</b>  |  |  |  | TITLE (SPECIFY) <b>Deputy Chief</b>  |  |   |  | DATE SIGNED <b>2/2/82</b>   |                                   |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Thomas D. Smith, M.D.</b>   |  |  |  | ADDRESS <b>111 Penn St. Balto., MD.</b>  |  |   |  |   |                                   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>   |  | 23b. DATE <b>2/4/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Westview Mem. Park</b>   |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>Catonsville</b>                       |                                   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS <b>Wm. C. March F/H 1101 E. North Ave.</b>  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>FEB 8 1982</b>   |  |   |                                   |   |  |

1000  
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1000

BP  
DHMH-16 30M 2/80  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |   |   |  |  |  |  |
|---|--|--|--|---|---|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  |   | 8 2 0 1 3 0 2   |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  |  |   | 2a. DATE OF DEATH   |  |  |  |  |
| EMERSON RICHARD MOORE   |  |  |  |   | MONTH DAY YEAR<br>1 2 82  |  |  |  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |   | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | 7b. HOUR   |  |
| MALE  |  | WHITE  |  | MONTH DAY YEAR<br>04 25 27  |   | 54 YRS.  |  | 2;22a <sub>M</sub>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |  |  |
| MARYLAND  |  | U.S.A.   |  |   |   | BALTIMORE CITY, MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                  |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| BALTIMORE   |  | VAMC   |  |   |   | Ret. Farmer  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |   | 13d. INSIDE CITY LIMITS   |  | 13e. STREET ADDRESS                        |  |  |
| 13a. STATE COUNTY<br>MARYLAND Dor.  |  |  |  |   | 13d. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                |  | 13e. ROUTE 2 CAMBRIDGE, MD 21613           |  |  |
| 14. FATHER'S NAME   |  |  |  |   | 15. MOTHER'S MAIDEN NAME  |  |  |  |  |
| FIRST MIDDLE LAST<br>RICHARD MOORE  |  |  |  |   | FIRST MIDDLE LAST<br>THERESA CONRAD   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)   |  |  |  |   | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS                      |  |  |
| YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> WWII  |  |  |  |   | 213244555   |  | VAMC MEDICAL RECORDS 3900 LOCH RAVEN BLVD  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY FAILURE</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>RENAL FAILURE, ANURIA</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>SEPTICEMIA, (R) RENAL ABSCESS</u>  |  |  |  |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |   |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |  |  |   |   | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>DECEMBER 23</u> 19 <u>81</u> , to <u>JANUARY 2</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>JANUARY 2</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |   |   |  |  |  |  |
| 22b. SIGNATURE  |  |  |  |   | DEGREE  |  | 22c. DATE SIGNED                           |  |  |
| K. Shaw-Taylor  |  |  |  |   |   |  | 1/2/82                                     |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  |   | 22e. ADDRESS  |  |  |  |  |
| K. SHAW-TAYLOR MD   |  |  |  |   | 3900 LOCH RAVEN BLVD 21218  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |  |  |
| burial  |  |  | 1/5/82   |   | Md. Veterans Cem.   |  | Beulah Dor. Md.                            |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Thomas Funeral Home Cambridge Md.   |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br>JAN 11 1982 James J. Nathan |  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 3 0 3

REG. NO.

|  |  |   |  |   |  |  |   |  |  |
|--|--|---|--|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Ernest none Moore</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1-4-82</b>                   |   |  | 2b. HOUR<br><b>4:45 A.M.</b>   |   |  |  |
| 3. SEX<br><b>male</b>  |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 17 02</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b>   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>79</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>La.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Bon Secours</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>retired</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>md</b>  |  |   | 13b. COUNTY<br><b>Balto</b>  |   | 13c. CITY OR TOWN<br><b>Balto</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Trent Moore</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Jimson</b>    |   |  | 13e. STREET ADDRESS<br><b>2401 W Lombard St 21223</b>  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>unknown</b>   |  |   | 16b. SOCIAL SECURITY NO.<br><b>217-03-3772</b>                         |   | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Alice Boyd - 2401 W. Lombard.</b>          |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>HYPOVOLEMIC SHOCK</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>TUMOR OF PANCREAS</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>CARCINOMA SUSPECTED.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br><b>15 79</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>HOURS 5 MOS.</b> |  |   |  |   |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |   |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>           |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1-03</b> 19 <b>82</b> to <b>1-04</b> 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>1-03</b> 19 <b>82</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br><b>Oscar E. Fernandini M.D.</b>  |  |   | DEGREE<br><b>M.D.</b>  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>1-04-82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>OSCAR E. FERNANDINI</b>  |  |   | 22e. ADDRESS<br><b>2000 W. BALTO. ST. BALTO. MD 21223</b>              |   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  |   | 23b. DATE<br><b>1-8-82</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Auburn</b>                        |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto Md.</b>                                  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>JAS. A. MORTON &amp; SONS</b>   |  |   | ADDRESS<br><b>1701 LAURENS</b>   |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 6 1982</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>James J. Keenan</b>   |  |



1. The first part of the report  
 is a general description of the  
 area. It is a small, flat, open  
 area, about 100 acres in size.  
 The soil is a light brown, sandy  
 loam. The vegetation is sparse,  
 consisting of low-lying shrubs  
 and grasses. The climate is  
 semi-arid, with hot summers  
 and mild winters. The water  
 supply is from a nearby river.  
 The population is small, about  
 500 people. The economy is  
 based on agriculture and  
 stock raising. The main  
 crops are wheat and barley.  
 The main stock is sheep.  
 The area is a typical example  
 of a semi-arid region in the  
 south-west of Australia.

2. The second part of the report  
 is a detailed description of the  
 area. It is a small, flat, open  
 area, about 100 acres in size.  
 The soil is a light brown, sandy  
 loam. The vegetation is sparse,  
 consisting of low-lying shrubs  
 and grasses. The climate is  
 semi-arid, with hot summers  
 and mild winters. The water  
 supply is from a nearby river.  
 The population is small, about  
 500 people. The economy is  
 based on agriculture and  
 stock raising. The main  
 crops are wheat and barley.  
 The main stock is sheep.  
 The area is a typical example  
 of a semi-arid region in the  
 south-west of Australia.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |   |   |  |   |  |   |  |
|--|--|--|---|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FRANCES MOORE   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1-2-82 |   |  | 2b. HOUR<br>7:45 M  |  |   |  |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>BLACK   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 11 22   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>59   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Lynchburg   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                    |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Maryland Balto City MD  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>F.H.N.C.    |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |   |   |  |   |  |   |  |
| 13b. COUNTY<br>BALTO   |  | 13c. CITY OR TOWN<br>BALTO   |   | 13e. STREET ADDRESS<br>2811 Spelman St  |  |   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William Johnson  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Ada Johnson           |   |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>213-20-5923 |   | 17. INFORMANT<br>ADDRESS<br>Ada Duckett 2420 Sandbury Rd  |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Acute Cardio Respiratory Arrest Instant<br>2500<br>DUE TO, OR AS A CONSEQUENCE OF (b) Arterio-sclerotic Cardio Vascular Disease years<br>DUE TO, OR AS A CONSEQUENCE OF (c) Probable pneumonia, years |  |  |   |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a   |  |  |   |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-16, 19 81, to 1-2, 19 82, that (I) (we) last saw the deceased alive on 1-2, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                      |  |  |   |   |  |   |  |   |  |
| 22b. SIGNATURE<br>Rodolfo V. Goco, Jr.   |  |  |   | DEGREE  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>1-2-82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Rodolfo V. Goco, Jr.  |  |  |   | 22e. ADDRESS<br>Federick Hill   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>1/6/82  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Md. Nat. Mem. Park  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Laurel Maryland   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>E.L. Phillips  |  |  |   | ADDRESS<br>1721-271 N. Monaca St.   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 7 1982   |  |   |  |



THE UNIVERSITY OF CHICAGO  
LIBRARY

74



10-22-1910  
J. Edgar Hoover  
Director  
U. S. Department of Justice  
Washington, D. C.

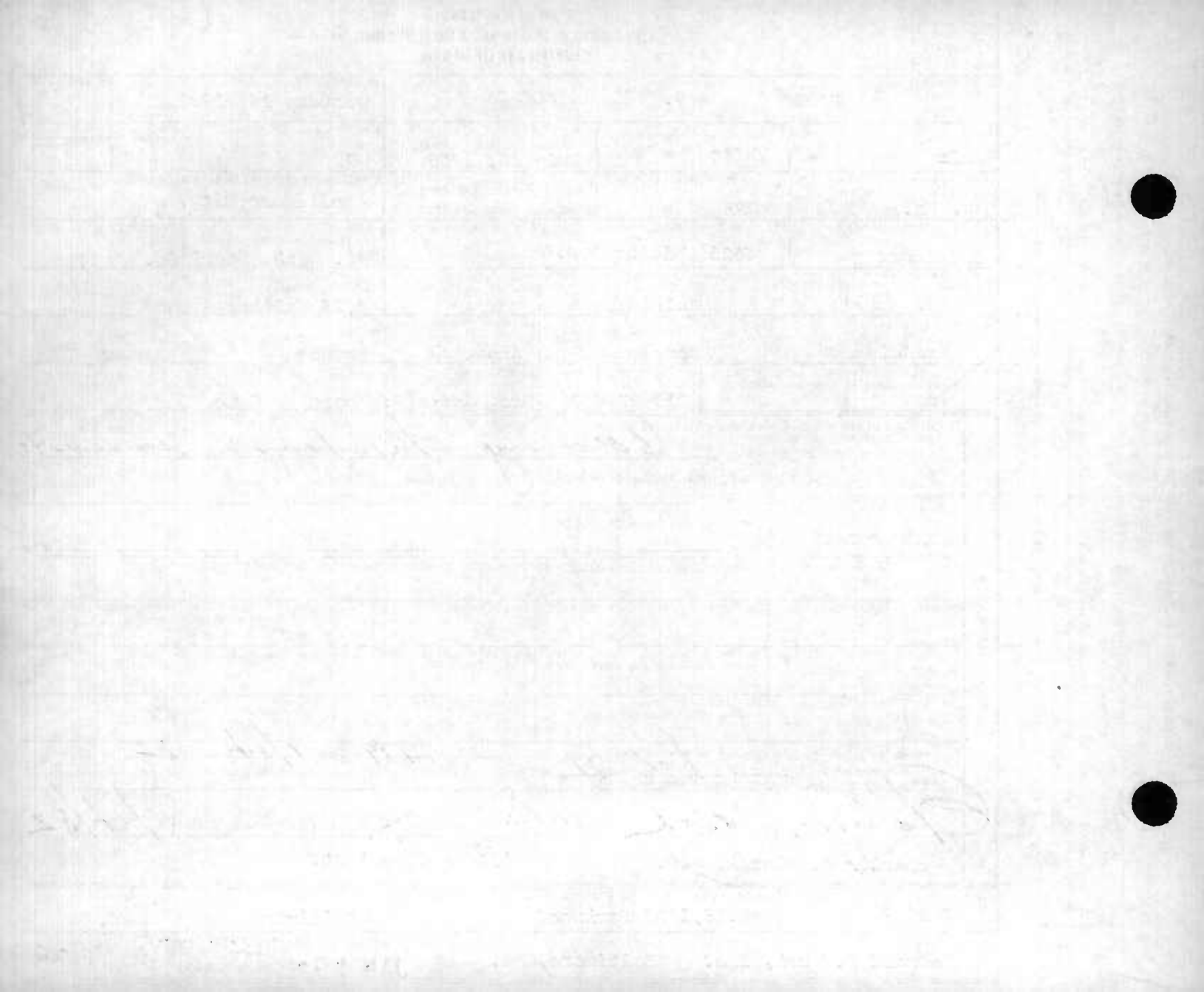
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |  |  |
|--|--|---|--|---|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 8 2 0 1 3 0 5   |  | REG. NO.  |  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>HARRY E. MOORE</b>   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 14, 1982</b>  |  | 2b. HOUR<br>M   |  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>July 16, 1909</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b> YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>W. Va.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City,</b> MD                               |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>4625 Walther Ave.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret. Beth. Steel Co.</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>4625 Walther Avenue</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Francis Moore</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anna Frances Tipman</b>   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR (UNKNOWN))<br><b>no</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>213-07-4839</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Anita S. Moore Same</b>   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b><br><b>4100</b> DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>immediate</b> |  |   |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1979</b> to <b>1/14</b> , 19 <b>82</b> , that (I) (we) lost (saw the deceased alive on <b>1/11/82</b> above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Charles J. Blazek</b> M.D.  |  |   |  | 22c. DATE SIGNED<br><b>1/14/82</b>  |  |   |  | 22d. ATTENDING MEDICAL STAFF<br>PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Charles J. Blazek, M.D.</b>  |  |   |  | 22f. ADDRESS<br><b>1116 St. Paul St.</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE OR PRINT)<br><b>Burial</b>  |  | 23b. DATE<br><b>Jan. 18, 1982</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>                              |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J. Ruck, Inc.</b>   |  |   |  | 24b. ADDRESS<br><b>Baltimore, Md.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 19 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>James Van Natta</b>   |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH-17  
(VR A15 ME (1))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|   |         |  |                   |
|---|---------|--|-------------------|
| 1- FOR STATE REGISTRAR  |         | 2 0 1 3 0 6  |                   |
| 1. DECEASED NAME (TYPE OR PRINT)  |         | 2b. DATE KNOWN OF DEATH                                  |                   |
| Jarvis  |         | XX MONTH DAY YEAR 1 23 1982                              |                   |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH   | 6. AGE (IN YEARS) |
| male  | black   | 8 3 06   | 75                |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |         | 7b. CITIZEN OF WHAT COUNTRY?                             |                   |
| N.C.  |         | USA  |                   |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION |                   |
| Baltimore   |         | Johns Hopkins Hospital                                   |                   |
| 13a. STATE  |         | 13b. COUNTY  |                   |
| MD  |         | Baltimore  |                   |
| 14. FATHER'S NAME   |         | 15. MOTHER'S MAIDEN NAME                                 |                   |
| John H. Moore   |         | Henrietta Boyd   |                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  |         | 16b. SOCIAL SECURITY NO.                                 |                   |
| No  |         | N/A  |                   |
| 17. INFORMANT   |         | ADDRESS  |                   |
| Louise Garrett  |         | 125 N. Colvin St.  |                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH             |                   |
| PART I DEATH WAS CAUSED BY: 8880  |         |  |                   |
| IMMEDIATE CAUSE (a) Complications of bilateral subdural hematomas   |         |  |                   |
| DUE TO, OR AS A CONSEQUENCE OF  |         |  |                   |
| (b)   |         |  |                   |
| DUE TO, OR AS A CONSEQUENCE OF  |         |  |                   |
| (c)   |         |  |                   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |         |  |                   |
| 19a. DATE OF OPERATION  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?        |                   |
|   |         |  |                   |
| 20. AUTOPSY?  |         |  |                   |
| YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |         |  |                   |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         | 21b. TIME OF INJURY                                      |                   |
|   |         | Est. 12/29 19 81   |                   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK   |         | 21e. PLACE OF INJURY                                     |                   |
|   |         | street   |                   |
| 21f. LOCATION   |         | 21g. LOCATION  |                   |
|   |         | ? Lombard Street, Baltimore City, MD                     |                   |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |  |                   |
| Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion  |         |  |                   |
| ACTUAL SIGNATURE  |         | TITLE (SPECIFY)  |                   |
| Virginia L. Dolan   |         | M.D. Assistant   |                   |
| EXAMINER'S NAME (TYPE OR PRINT)   |         | DATE SIGNED  |                   |
| Virginia L. Dolan, M.D.   |         | 1/25/82  |                   |
| ADDRESS   |         |  |                   |
| 111 Penn Street, Balto., MD 21201   |         |  |                   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |         | 23b. DATE  |                   |
| Burial  |         | 1/29/82  |                   |
| 23c. NAME OF CEMETERY OR CREMATORY  |         | 23d. LOCATION  |                   |
| Westview Mem. Pk.   |         | Baltimore Co MD  |                   |
| 24. FUNERAL DIRECTOR  |         | 25. DATE REC'D. BY REGISTRAR                             |                   |
| Wm. C. March F/H 1101 E. North Ave.   |         | JAN 26 1982  |                   |

James J. Nathan



Items #18a-22a Film G565 3/30/82 STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |                             |   |  |   |
|--|-----------------------------|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Rodney Moore</b>   |                             | 2a. DATE KNOWN OF DEATH<br>ESTIMATED<br>MONTH DAY YEAR<br><b>1 22 19 82</b> |  | 2b. HOUR<br>M<br><b>2:54 PM</b>   |
| 3. SEX<br><b>male</b>  | 4. RACE<br><b>black</b>     | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 9 55</b>                         | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br><b>27 YRS.</b> | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.<br><b>27</b>   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |                             | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                               |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>  |                             | 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                               |  |   |
| 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University Hospital DOA</b>   |                             | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)               |  | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. STATE<br><b>Maryland</b>  |                             | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James Moore</b>   |                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Georgia Mae Brown</b>   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>   |                             | 16b. SOCIAL SECURITY NO.<br><b>214-64-0482</b>                              |  | 17. INFORMANT<br>ADDRESS<br><b>James Moore 24 Bantry Court</b>  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>3049</b> IMMEDIATE CAUSE (a) <b>Narcotism</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |                             |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |                             |   |  |   |
| 19a. DATE OF OPERATION   |                             | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                           |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                             | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                             | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                 |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                             |   |  |   |
| ACTUAL SIGNATURE<br><b>Margarita A. Korell</b>   |                             | TITLE (SPECIFY)<br><b>Assistant</b>   |  | DATE SIGNED<br><b>1/23/82</b>   |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Margarita A. Korell, M.D.</b>   |                             | ADDRESS<br><b>111 Penn Street, Balto. MD 21201</b>                          |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  | 23b. DATE<br><b>1/27/82</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview Cemetery</b>              | 23d. LOCATION<br>CITY OR TOWN<br><b>Baltimore</b>      | COUNTY<br><b>MD</b>   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm C. Brown Comm F/H</b>  |                             | ADDRESS<br><b>1206-08 W. North Ave.</b>                                     |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 1 1982</b>  |
| 25b. REGISTRAR'S SIGNATURE<br><b>James J. [Signature]</b>  |                             |   |  |   |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



RECEIVED  
FEB 1 1934

FEB 1 1934



Items 7a, 8 g564 2/17/82 gj

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 3 0 8

FOR  
1- STATE  
REGISTRAR

REG. NO.

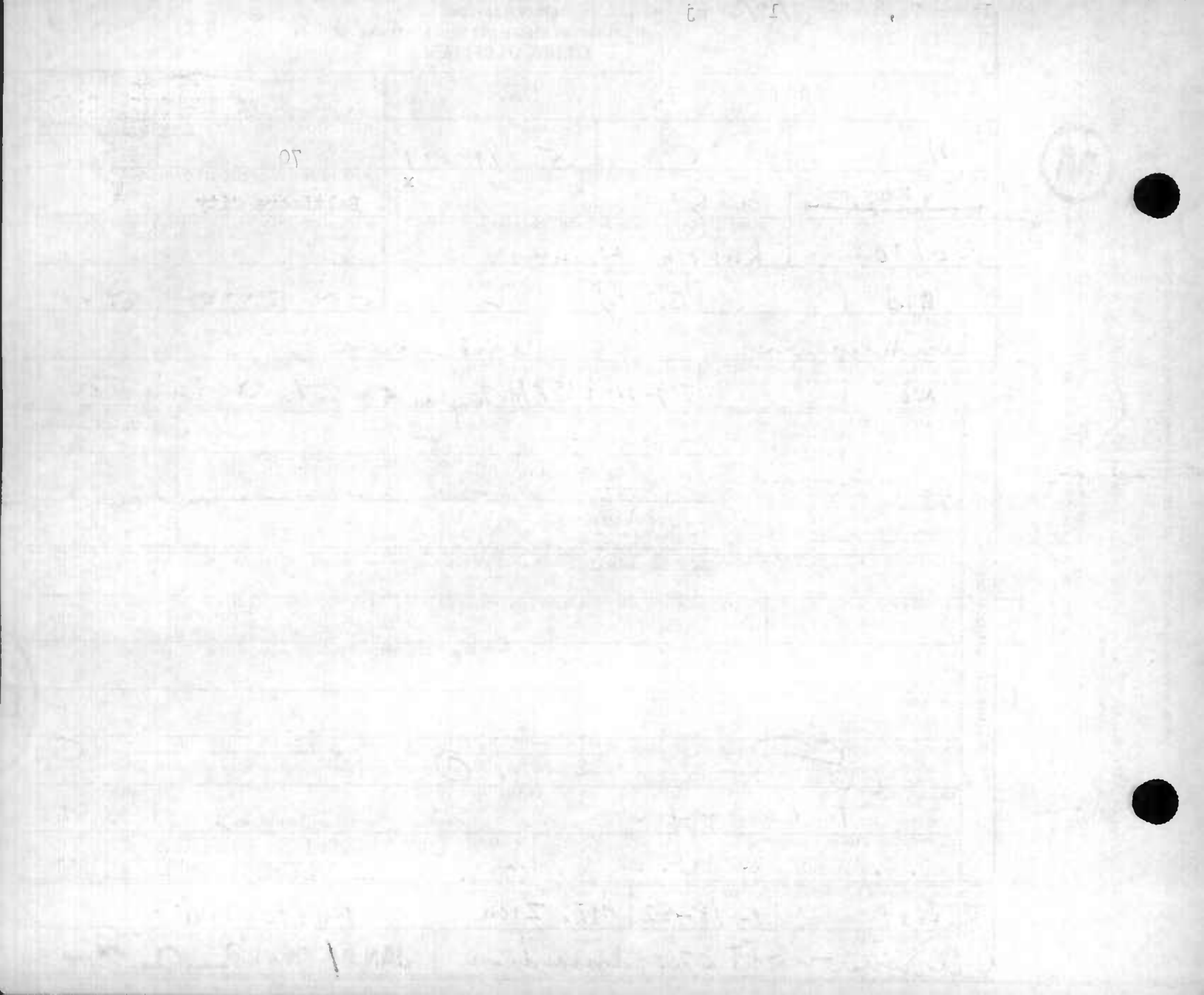
|   |   |   |  |  |  |
|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>GEORGE T. MORAN</b>  |   |   | 2a. DATE OF DEATH<br>MONTH <b>01</b> DAY <b>13</b> YEAR <b>82</b>                          |  | 2b. HOUR<br><b>2:40pm</b>  |
| 3. SEX<br><b>M</b>  | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH <b>5</b> DAY <b>11</b> YEAR <b>11</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Church Home</b> |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                 | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br><b>MD</b>   |   | 13b. COUNTY   | 13c. CITY OR TOWN<br><b>Baltimore</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  | 13e. STREET ADDRESS<br><b>5 N. Euter St.</b>   |
| 14. FATHER'S NAME<br>FIRST <b>Unknown</b> MIDDLE <b>Unknown</b> LAST <b>Unknown</b>   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Unknown</b> MIDDLE <b>Unknown</b> LAST <b>Unknown</b> |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>219-01-8357</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>H. Taylor 5 N. Euter St. Director</b>                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b><br><b>1629</b> DUE TO, OR AS A CONSEQUENCE OF <b>LUNG CANCER WITH METASTASES</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>PARAPLEGIA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>PARAPLEGIA</b> |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |   |   |  |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                        | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) this hospital attended the deceased from <b>01-13-82</b> to <b>01-13-82</b> , that (I) (we) last saw the deceased alive on <b>01-13-82</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.   |   |   |  |  |  |
| 22b. SIGNATURE<br><b>J. Kawaja</b>  |   |   |  | 22c. DATE SIGNED<br><b>1-13-82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. J. KAWAJA KAWAJA M.D.</b>   |   |   |  | 22e. ADDRESS<br><b>CHURCH HOSPITAL CORPORATION<br/>100 N. BROADWAY BALTIMORE, MARYLAND 21231</b> |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |   | 23b. DATE<br><b>1-18-82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MT. Zion</b>  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 21 1982</b>   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>C. Wainwright</b>  |   | ADDRESS<br><b>2700 Edmondson</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>James J. Smith</b>  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN FILES FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| FOR<br>1- STATE<br>REGISTRAR   |  |         |  |   |  |                                    |  |  |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH |  |  |  |  |  |   |  |  |  | REG. NO.  |  |
|--|--|---------|--|---|--|------------------------------------|--|--|--|--|--|--|--|--|--|---|--|--|--|-----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |         |  |   |  |                                    |  |  |  | 2a. DATE KNOWN OF DEATH  |  |  |  |  |  |   |  |  |  | 2b. HOUR  |  |
| FIRST MIDDLE LAST<br>JOSEPH W. MORECRAFT   |  |         |  |   |  |                                    |  |  |  | MONTH DAY YEAR<br>1 3 1982   |  |  |  |  |  |   |  |  |  | M<br>6:05 |  |
| 3. SEX   |  | 4. RACE |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS)                  |  | IF UNDER 1 YR.   |  | IF UNDER 24 HRS.   |  | 7c. DATE PRONOUNCED DEAD                   |  | 2d. HOUR                                     |  |   |  |  |  |           |  |
| male   |  | white   |  | Feb. 12, 1922   |  | 59 YRS.                            |  | MONTHS DAYS HOURS MIN  |  |  |  | 1 3 1982                                   |  | M  |  |   |  |  |  |           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |         |  | 7b. CITIZEN OF WHAT COUNTRY?  |  |                                    |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH       |  |  |  |   |  |  |  |           |  |
| Maryland   |  |         |  | USA   |  |                                    |  |  |  |  |  | Baltimore City MD.                         |  |  |  |   |  |  |  |           |  |
| 10. CITY OR TOWN OF DEATH  |  |         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                                    |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY          |  |  |  |   |  |  |  |           |  |
| Baltimore  |  |         |  | South Balto. Gen. Hosp. (DOA)   |  |                                    |  | Sheet Metal worker, Beth. Steel  |  |  |  |  |  |  |  |   |  |  |  |           |  |
| 13a. STATE   |  |         |  | 13b. COUNTY   |  | 13c. CITY OR TOWN                  |  | 13d. INSIDE CITY LIMITS?   |  | 13e. STREET ADDRESS  |  |  |  |  |  |   |  |  |  |           |  |
| Maryland   |  |         |  |   |  | Baltimore                          |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 1632 Belt St. Balto. Md.   |  |  |  |  |  |   |  |  |  |           |  |
| 14. FATHER'S NAME  |  |         |  |   |  |                                    |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |   |  |  |  |           |  |
| FIRST MIDDLE LAST<br>Harry ----- Morecraft   |  |         |  |   |  |                                    |  |  |  | FIRST MIDDLE LAST<br>Catherine ----- Bardeman                                      |  |  |  |  |  |   |  |  |  |           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |  |         |  |   |  |                                    |  |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS                      |  |  |  |   |  |  |  |           |  |
| Yes  |  |         |  |   |  |                                    |  |  |  | W.W. 2   |  | 217-16-0301 Mrs. Doris Cage, Same as above |  |  |  |   |  |  |  |           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease<br>4292<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |         |  |   |  |                                    |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |  |  |           |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |         |  |   |  |                                    |  |  |  |  |  |  |  |  |  |   |  |  |  |           |  |
| 19a. DATE OF OPERATION   |  |         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |                                    |  |  |  |  |  |  |  |  |  | 20. AUTOPSY?  |  |  |  |           |  |
|  |  |         |  |   |  |                                    |  |  |  |  |  |  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |           |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |         |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  |  |                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |  |  |  |  |   |  |  |  |           |  |
|  |  |         |  | P.M. 19   |  |                                    |  |  |  |  |  |  |  |  |  |   |  |  |  |           |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |  |         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |   |  |  |  |           |  |
|  |  |         |  |   |  |                                    |  |  |  |  |  |  |  |  |  |   |  |  |  |           |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |         |  |   |  |                                    |  |  |  |  |  |  |  |  |  |   |  |  |  |           |  |
| TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER   |  |         |  |   |  |                                    |  |  |  |  |  |  |  |  |  |   |  |  |  |           |  |
| DATE SIGNED 1-3-82   |  |         |  |   |  |                                    |  |  |  |  |  |  |  |  |  |   |  |  |  |           |  |
| ACTUAL SIGNATURE <i>Ann M. Dixon</i>   |  |         |  |   |  |                                    |  |  |  |  |  |  |  |  |  |   |  |  |  |           |  |
| EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. ADDRESS 111 Penn St.  |  |         |  |   |  |                                    |  |  |  |  |  |  |  |  |  |   |  |  |  |           |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |         |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |  |  |  |  |   |  |  |  |           |  |
| Burial   |  |         |  | Jan. 8, 1982  |  | Md. Vet. Cent, Crownsville         |  |  |  | Crownsville, Maryland  |  |  |  |  |  |   |  |  |  |           |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS  |  |         |  |   |  |                                    |  |  |  | 25a. DATE RECD. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE                 |  |  |  |   |  |  |  |           |  |
| McUilly Funeral Home. 130 E. Fort Ave. Balto. Md.  |  |         |  |   |  |                                    |  |  |  | JAN 5 1982   |  | <i>Ann M. Dixon</i>                        |  |  |  |   |  |  |  |           |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. Page 3 should be filed within 72 hours after death.

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(VRA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |   |  |  |  |  |  |
|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  | 2a. DATE OF DEATH   |  |  | 2b. HOUR   |  |  |
| LAWRENCE ELWOOD MORGAN   |  |  | 1 22 82   |  |  | 7:51 P.M.  |  |  |
| 3. SEX   | 4. RACE  | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY)                               |  |  | 7. IF UNDER 1 YEAR   |  |  |
| Male   | Caucasian  | 10 24 13   | 68  |  |  | MONTHS DAYS HOURS MIN.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                          |  |  |  |  |  |
| North Carolina   | U. S. A.   |  | Baltimore MD.   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |  |
| Baltimore  | VAMC Baltimore Maryland 21218  |  |   |  |  |  |  |  |
| 13a. STATE   | 13b. COUNTY  | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS?                                      | 13e. STREET ADDRESS  |  |  |  |  |
| Maryland   | Howe   | Ellicott City  | YES <input type="checkbox"/> NO <input type="checkbox"/>      | 8534 Linwood Drive   |  |  |  |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |   | ADDRESS  |  |  |  |  |
| Albert   |  | Louella  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT  |  |  |  |  |
| Yes  |  | WWII   |   | 242-16-0844 VAMC records, Baltimore, Maryland 21218                            |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:  |  |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>cardio pulmonary arrest</u>   |  |  |   |  |  |  |  | minutes                                      |
| 5188 DUE TO, OR AS A CONSEQUENCE OF (b) <u>respiratory failure</u>   |  |  |   |  |  |  |  | minutes                                      |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>chronic interstitial lung disease</u>   |  |  |   |  |  |  |  | YRS  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:   |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |
|  |  |  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |  |
|  |  | P.M. 19  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |  |  |  |
|  |  |  |   |  |  |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from <u>January 20</u> , 19 <u>82</u> , to <u>January 22</u> , 19 <u>82</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>January 22</u> , 19 <u>82</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <u>not</u> view the body after death. |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE   |  | DEGREE   |   | 22c. DATE SIGNED   |  |  |  |  |
| <u>J. Posner, MD</u>   |  |  |   | 1/23/82  |  |  |  |  |
| 22d. THE SIGNATURE'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |   |  |  |  |  |  |
| J. Posner, MD  |  | VAMC, Baltimore, Maryland 21218  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                        |  |  |
| Burial   |  | Jan 26   |   | Greenlawn Memorial Pk  |  | Wilmington NC  |  |  |
| 24. FUNERAL DIRECTOR   |  | 25a. DATE REC'D. BY REGISTRAR  |   |  |  |  |  |  |
| H Witzke   |  | JAN 25 1982  |   |  |  |  |  |  |
| 4112 Columbia Rd, Ellicott City Md   |  |  |   |  |  |  |  |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 8 2 0 1 3 1 1   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Bernard S. Morris  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1 21 82 900 A.M.   |  |  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>2 7 1930  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>51 YRS  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore City Hospital |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Field Clerk   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Beth. Steel   |  |
| 13a. STATE<br>Maryland  |  |  |  | 13b. CITY OR TOWN<br>Dundalk  |  | 13c. STREET ADDRESS<br>13 Dundalk Avenue   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Thomas Narutowicz   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Theresa B. Kolodziej   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>218-28-5764   |  | 17. INFORMANT<br>ADDRESS 13 Dundalk Avenue<br>Dr. Richard J. Morris Balto., MD. 21222   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardio pulmonary arrest</u><br>4275<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Septic shock</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Bruce Kinosian</u>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br>1/20/81  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Bruce Kinosian   |  |  |  | 22e. ADDRESS  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation   |  | 23b. DATE<br>1/22/1982   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Green Mount   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland   |  |
| 24. FUNERAL DIRECTOR<br>NAME Duda-Ruck, Inc.<br>7922 Wise Avenue Dundalk, MD. 21222   |  |  |  | 25a. DATE RECEIVED BY REGISTRAR<br>JAN 25 1982  |  |  |  |



THE ASSOCIATED PRESS  
NEW YORK, N. Y.  
JAN 21 1952

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JAN 21 1952  
JAMES EARL RAY  
MEMPHIS, TENN.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO.  |  |   |   |
|---|--|--|--|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MAMIE MORRIS</b>   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1-28-82</b>   |  | 2b. HOUR<br><b>12:09AM</b>  |   |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2-6-1901</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b> YRS.   |   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Church Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Home Maker</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |   |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Balto.</b>   |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                               |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Wesley Shifflett</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ella Collier</b>  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>214-18-3730</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Estelle M. Sandridge - 7331 Kirtley Rd. 21224</b>   |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ACUTE RENAL FAILURE</b><br><b>2765</b> DUE TO, OR AS A CONSEQUENCE OF <b>ACUTE URINARY TRACT INFECTION</b><br>(b) <b>WITH PROBABLE ACUTE PAPILLARY NECROSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>HYPERGLYCEMIA AND DEHYDRATION</b><br>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE, CONGESTIVE HEART FAILURE,<br><b>DIABETES MELLITUS, ORGANIC BRAIN SYNDROME</b> |  |  |  |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY BY ITEM 18, PART I OR PART 2)  |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>1-26</b> <b>19</b> <b>82</b> to <b>1-28</b> <b>19</b> <b>82</b> that (1) (we) last saw the deceased on <b>1-28</b> <b>19</b> <b>82</b> and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.   |  |  |  |   |  |   |   |
| 22b. SIGNATURE<br><b>A. F. NOUR</b> MD  |  |  |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>1-28-82</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>A. F. NOUR, MD.</b>   |  |  |  | 22e. ADDRESS<br><b>CHURCH HOSPITAL CORPORATION 100N. BROADWAY BALTIMORE, MARYLAND 21231</b>   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>  |  | 23b. DATE<br><b>1-31-82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Evergreen Church Cem.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Dyke Green Co., Va.</b>  |   |
| 24. FUNERAL DIRECTOR<br><b>John C. Miller Inc-6415 Belair Rd.-21206</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 1 1982</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Thomas J. Smith</b>  |   |

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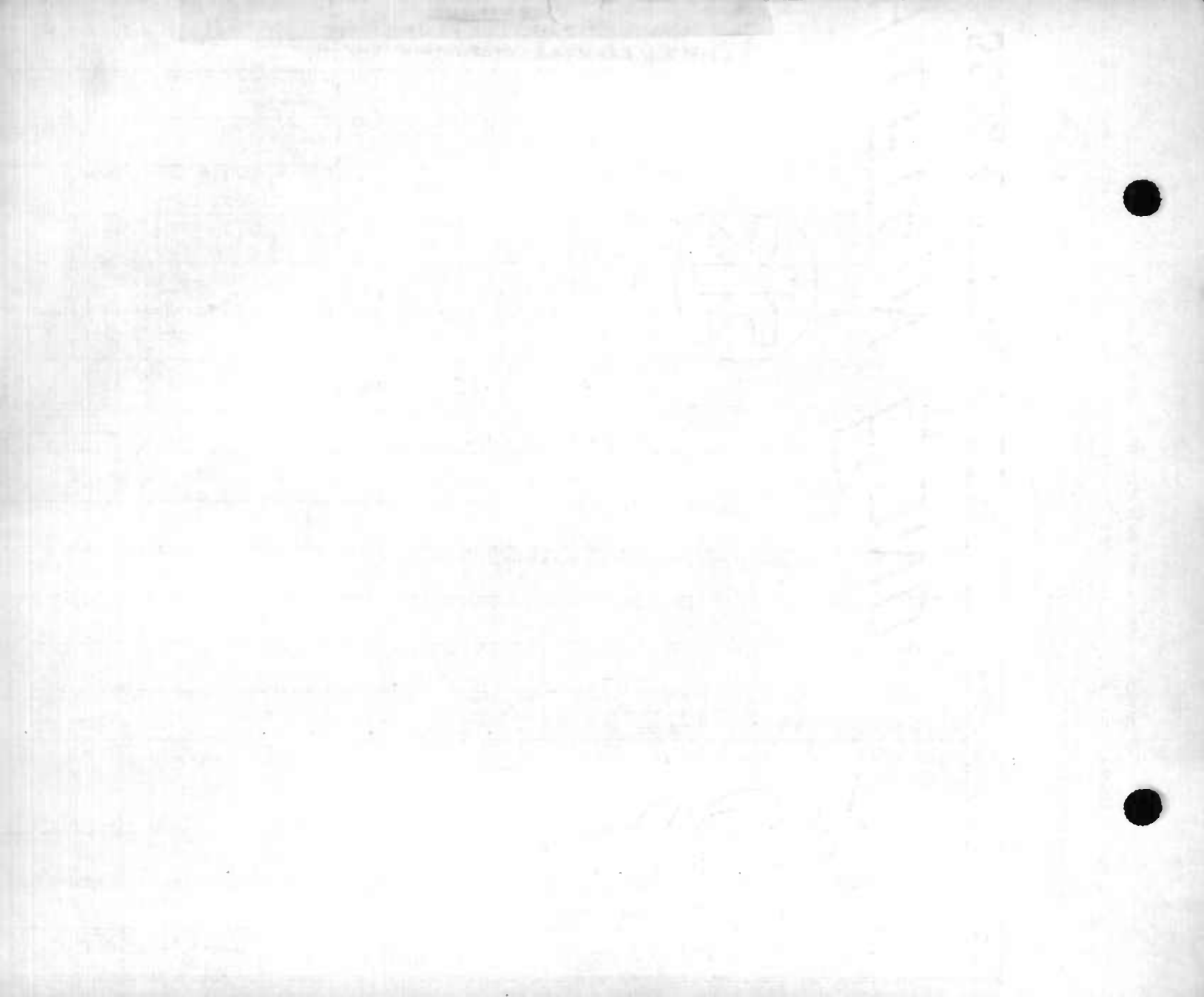
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |  | REG. NO. 2 0 1 3 1 3   |  |
|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  |  |  |  |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>THERESA S. MORRIS  |  |  |  |  |  |  |  |  |  | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br>1 14 19 82 |  |
| 3. SEX female 4. RACE negro 5. DATE OF BIRTH MONTH DAY YEAR<br>9 9 77 6. AGE (IN YEARS) 4 7. IF UNDER 1 YR. MONTHS DAYS 8. IF UNDER 24 HRS. HOURS MIN.   |  |  |  |  |  |  |  |  |  | 2b. DATE PRONOUNCED DEAD MONTH DAY YEAR<br>1 14 19 82  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD 7b. CITIZEN OF WHAT COUNTRY? USA 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |
| 10. CITY OR TOWN OF DEATH Baltimore 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University Hospital (DOA)   |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 12b. KIND OF BUSINESS OR INDUSTRY    |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE MD 13b. COUNTY 13c. CITY OR TOWN Baltimore 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 8 S. Carey St.  |  |  |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>William L. Morris 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Joann Drumwright  |  |  |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No (IF YES, GIVE WAR OR DATES) 16b. SOCIAL SECURITY NO. N/A 17. INFORMANT ADDRESS<br>Joann Drumwright 1005 N. Payson St.  |  |  |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>9680 IMMEDIATE CAUSE (a) Smoke inhalation<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c) DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |  |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>1:58 PM 1-14-1982 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>House fire.  |  |  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) house 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br>8 S. Carey St. Balto. MD.   |  |  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE [Signature] TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER DATE SIGNED 1-14-82   |  |  |  |  |  |  |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. ADDRESS 111 Penn St.  |  |  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE 1/19/82 23c. NAME OF CEMETERY OR CREMATORY Westview Mem. Pk. 23d. LOCATION CITY OR TOWN COUNTY MD<br>Baltimore Co. MD   |  |  |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/H ADDRESS 1101 E. North Ave. 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br>JAN 18 1982 [Signature]  |  |  |  |  |  |  |  |  |  |  |  |

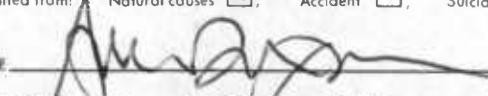

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGES 1, 2, AND 3 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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| Items #10a-22a Film G564 2/3/82 re STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                          |  |   |  |  |  |   |  | 2 0 1 3 1 4<br>REG. NO.                                    |  |                                   |  |
|--|--|--------------------------|--|---|--|--|--|---|--|--|--|-----------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>MILTON H. MORRISON  |  |                          |  |   |  |  |  |   |  | 2a. DATE KNOWN OF DEATH<br>MONTH DAY YEAR<br>1 2 1982      |  | 2b. HOUR<br>M<br>2:25 P           |  |
| 3. SEX<br>male   |  | 4. RACE<br>negro         |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>6 15 28   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>53 YRS.  |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  |  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>1 2 1982     |  | 2d. HOUR<br>M<br>2:25 P           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Georgia   |  |                          |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD. |  |                                   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |                          |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>100 blk. N. Gay St. |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |                          |  |   |  |  |  |   |  |  |  |                                   |  |
| 13a. STATE<br>MD   |  | 13b. COUNTY<br>BALTIMORE |  | 13c. CITY OR TOWN<br>Glen Burnie  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>456 Longtown Court   |  |  |  |                                   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William Morrison   |  |                          |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Inez Williams  |  |  |  |   |  |  |  |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No  |  |                          |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>N/A  |  | 17. INFORMANT ADDRESS<br>Bishop William Morrison 11 W. 20th St. #G                   |  |   |  |  |  |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Hypertensive cardiovascular disease</u><br>4029<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF  |  |                          |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH               |  |                                   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                          |  |   |  |  |  |   |  |  |  |                                   |  |
| 19a. DATE OF OPERATION   |  |                          |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |                                   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                          |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)        |  |   |  |  |  |                                   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |  |                          |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |  |  |                                   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                          |  |   |  |  |  |   |  |  |  |                                   |  |
| ACTUAL SIGNATURE<br>  |  |                          |  | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER  |  |  |  | DATE SIGNED 1-3-82  |  |  |  |                                   |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Ann M. Dixon, M.D.  |  |                          |  | ADDRESS<br>111 Penn St.   |  |  |  |   |  |  |  |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |                          |  | 23b. DATE<br>1/7/82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Arbutus Memorial Park                          |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Arbutus MD  |  |  |  |                                   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Wm. C. March F/H, Inc. 1101 E. North Ave.  |  |                          |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 6 1982  |  |   |  |  |  |                                   |  |
| 25b. REGISTRAR'S SIGNATURE<br>  |  |                          |  |   |  |  |  |   |  |  |  |                                   |  |



NEW YORK  
JUN 10 1891  
JUN 10 1891

NEW YORK



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| Items 21d., -21f., & 22a.   |  |  |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 8 2 0 1 3 1 5  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  | Ffilm#G564 2-9-82  |  |  |  | CERTIFICATE OF DEATH                                     |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  |  | 2a. DATE OF DEATH  |  |  |  | REG. NO.   |  |  |  |
| OLIVER H. MORROW  |  |  |  | Jan. 01 82   |  |  |  | 9:45 A. M.   |  |  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS.   |  |
| Male  |  | White  |  | 2 25 98  |  | 83   |  | MONTHS   |  | DAYS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |  |  |  |  |
| Maryland  |  | U.S.A.   |  |  |  | Baltimore City   |  |  |  | MD.  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |  |
| Baltimore   |  | Shock Trauma 22 S. Greene St.  |  | Maintenance  |  | Balto. City  |  |  |  |  |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?   |  | 13e. STREET ADDRESS                                      |  |  |  |
| Maryland  |  |  |  | Baltimore  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 930 Lombard Street                                       |  | 21223  |  |
| 14. FATHER'S NAME   |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |  |  |
| William Morrow  |  |  |  | Mary V. Ryle   |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |  | 16b. SOCIAL SECURITY NO.   |  |  |  | 17. INFORMANT ADDRESS                                    |  |  |  |
| YES   |  |  |  | WW I   |  |  |  | Roberta Weippert 1915 Frederick Ave. 21223               |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |  |  |  |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |  |  |  |  |  |  |  |  |
| 8990 IMMEDIATE CAUSE (a) Carbon monoxide intoxication + Respiratory burn  |  |  |  |  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last   |  |  |  | (b) FIRE victim  |  |  |  | 15 days  |  |  |  |
|   |  |  |  | (c) Cardiovascular + Renal failure   |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |  |  |  |  |  |  |
| COPD.   |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
| None  |  |  |  |  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |  |  |
|   |  |  |  | HOUR A.M. MONTH DAY YEAR   |  | Fire.  |  |  |  |  |  |
| 21d. INJURY OCCURRED  |  |  |  | 21e. PLACE OF INJURY   |  | 21f. LOCATION  |  |  |  |  |  |
| WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NA  |  |  |  | NA   |  | STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/27 1981, to 1/1 1982, that (I) (we) last saw the deceased alive on 1/1 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. |  |  |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE  |  |  |  | DEGREE   |  |  |  | 22c. DATE SIGNED   |  |  |  |
| DUNG Q. TRAN  |  |  |  | M.D.   |  |  |  | 1/1/82   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | 22e. ADDRESS   |  |  |  |  |  |  |  |
| DUNG Q. TRAN  |  |  |  | Shock Trauma, Maryland   |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION  |  |  |  |
| Burial  |  |  |  | 1/8/82   |  | Crownsville Vets. Cem  |  | Crownsville A.A. Co. Md.                                 |  |  |  |
| 24. FUNERAL DIRECTOR  |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  |  |  | 25b. REGISTRAR'S SIGNATURE                               |  |  |  |
| Hubbard Funeral Home, Inc. 4107 Wilkens Ave.  |  |  |  | JAN 6 1982   |  |  |  | Charles J. Nathan  |  |  |  |

2

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director. The funeral director should be detached for use as the burial-transit permit. Then please remove carbon paper and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| Items 13a-e, 15 per phone 2/2/82 STATE OF MARYLAND  |  |   |  |   |   |   |  |  |                                   |
|---|--|---|--|---|---|---|--|--|-----------------------------------|
| DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |   |   |   |  |  |                                   |
| CERTIFICATE OF DEATH  |  |   |  |   |   |   |  |  |                                   |
| REG. NO. 8 2 0 1 3 1 6  |  |   |  |   |   |   |  |  |                                   |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Christopher Eric Mosley</b>  |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1-9-82</b>                |   | 2b. HOUR<br><b>7:48 AM</b>   |  |                                   |
| 3. SEX<br><b>M</b>  |  | 4. RACE<br><b>W</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 7 82</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>2 days</b>  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO COUNTY MD</b>  |  |  |                                   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BALTO CITY HOSPITAL</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |                                   |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>BALTO</b>   |  | 13c. CITY OR TOWN<br><b>BALTO</b>   |   | 13d. INSIDE CITY LIMITS?<br><b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>634 Mansfield Rd. 21221</b>  |                                   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Alfred Eugene Mosley</b>   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Mosley</b> |   |  |  |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br>ADDRESS<br><b>Alfred Eugene Mosley (Father)</b>  |   |   |  |  |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiorespiratory Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Intracerebral Hemorrhage</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Prematurity</b>   |  |   |  |   |   |   |  |  |                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>Pulmonary Hemorrhage</b>   |  |   |  |   |   |   |  |  |                                   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |   | 20a. AUTOPSY?<br><b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/> |                                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |  |  |                                   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |  |                                   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>7 January 19 82</b> to <b>9 January 19 82</b> that (I) (we) lost saw the deceased alive on <b>9 January 19 82</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |   |   |  |  |                                   |
| 22b. SIGNATURE<br><b>Lawrence M. Noyce</b>  |  |   |  |   | DEGREE<br><b>MD</b>   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1/9/82</b> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Lawrence M. Noyce</b>   |  |   |  |   | 22e. ADDRESS<br><b>Baltimore City Hospital</b>                      |   |  |  |                                   |
| 23a. BURIAL <input type="checkbox"/> CREMATION <input type="checkbox"/> REMOVAL <input checked="" type="checkbox"/>   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |  |                                   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Removal by Hospital</b>  |  |   |  |   | 25. DATE RECEIVED BY REGISTRAR<br><b>JAN 29 1982</b>                |   | 26. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |                                   |

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 3 1 7

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |  |  |   |                            |  |   |
|---|--|--|--|---|----------------------------|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Carroll Stow Murphy</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>01/29/82</b> |   | 2b. HOUR<br><b>5:19 PM</b> |  |   |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec 28 1916</b>  |                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>65</b> YRS.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Baltimore</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Johns Hopkins Hospital</b> |  |   |                            | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Meat Inspector-Civil Ser.</b>                       |   |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>AA</b>   |  | 13c. STREET ADDRESS<br><b>4 Third Avenue</b>  |                            | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Michael J. Murphy</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Jennie A. Peiffer</b>   |                            |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>216-01-7260</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Selma C. Murphy, Same as 13</b>  |                            |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4149</b> IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Unknown</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |                            |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 hr</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Recent Coronary Artery bypass</b>   |  |  |  |   |                            |  |   |
| 19a. DATE OF OPERATION<br><b>1/25/82</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Coronary Artery Disease</b>   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                            |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                            |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>January 25, 1982</b> to <b>January 29, 1982</b> , that (I) (we) lost<br>saw the deceased alive on <b>January 29, 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. <b>5:14 pm</b>  |  |  |  |   |                            |  |   |
| 22b. SIGNATURE<br><b>George M White</b>   |  |  |  | 22c. DATE SIGNED<br><b>1/29/82</b>  |                            | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>George White</b>   |   |
| 22e. ADDRESS<br><b>Johns Hopkins Hospital</b>   |  |  |  | 22f. DATE RECD. BY REGISTRAR<br><b>FEB 1 1982</b>   |                            |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>2 Feb 82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cem.</b>   |                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore</b>   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>James S. Kirkley, Glen Burnie, MD</b>  |  |  |  | 25. DATE RECD. BY REGISTRAR<br><b>FEB 1 1982</b>  |                            |  |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



NOTES, X.O

[Faint, mostly illegible text covering the majority of the page, appearing to be a document or report.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 8 2 0 1 3 1 8  |  |   |  |  |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST  |  | MIDDLE  |  | LAST   |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  | 2b. HOUR                                     |  |
| GRACE  |  | S  |  |   |  | MURPHY   |  | 1 / 19 / 82   |  | 930A <sup>M</sup>                            |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | 7. UNDER 1 YEAR MONTHS DAYS   |  | 8. UNDER 24 HRS. HOURS MIN.                  |  |
| F  |  | B  |  | 9 04 09   |  | 72 YRS   |  |   |  |  |  |
| 10. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 11. CITIZEN OF WHAT COUNTRY?   |  | 12. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |   |  |  |  |
| HAI. FAX CO. VA.   |  | USA  |  |   |  | BALTIMORE CITY MD.   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  |  |  |   |  |  |  |
| Baltimore City   |  | UNIV OF MARYLAND HOSP  |  |   |  |  |  |   |  |  |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |  |  |   |  |  |  |
| HOUSEWIFE  |  |  |  |   |  |  |  |   |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13b. STATE   |  | 13c. COUNTY   |  | 13d. CITY OR TOWN  |  | 13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  | 13f. STREET ADDRESS                          |  |
| MD.  |  |  |  |   |  | BALTIMORE  |  |   |  | 2904 WINDSOR AVE                             |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |   |  |  |  |   |  |  |  |
| DANIEL   |  | FAULKNER   |  | SARAH   |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS   |  |  |  |   |  |  |  |
|  |  | 213-09-0723  |  | MARGARET MURPHY 4104 ETHLAND AVE  |  |  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:  |  |  |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| IMMEDIATE CAUSE (a) 2030 CARDIO-PULMONARY ARREST   |  |  |  |   |  |  |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) EXTENSIVE MULTIPLE MYELOMA  |  |  |  |   |  |  |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |   |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |  |  |
|  |  | P.M. 19  |  |   |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |  |  |
|  |  |  |  |   |  |  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/16, 19 81, to 1/19, 19 82, that (I) (we) last saw the deceased alive on 1/19/19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE   |  | DEGREE   |  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED  |  |  |  |
| Robert H. Lewis MD   |  |  |  |   |  |  |  | 1/19/82   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |   |  |  |  |   |  |  |  |
| Robert H. Lewis  |  | Univ. of Md. Hosp. & Med. Ctr.   |  |   |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| BURIAL   |  | 1/23/82  |  | MD. NAT'L MEMORIAL PK   |  | LAUREL MD.   |  |   |  |  |  |
| 24. FUNERAL DIRECTOR NAME  |  | 25a. DATE REC'D. BY REGISTRAR  |  |   |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |  |  |
| JAMES A. Markon  |  | 1701 LAURENS ST.   |  |   |  | JAN 21 1982  |  | James J. Markon   |  |  |  |





Handwritten notes and a table on lined paper. The text is mostly illegible due to blurriness and bleed-through from the reverse side. The table has several columns and rows of data, with some entries appearing to be dates or numerical values. There are also some larger, less distinct markings or stamps on the page.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH-17  
(VRA15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |                  |   |   |  |   |  |   |  |
|--|------------------|---|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Tammy Jane Murphy   |                  |   | 2a. DATE KNOWN OF DEATH<br>MONTH DAY YEAR<br>1 5 1982                 |  |   | 2b. HOUR<br>M<br>2:50 P. M.  |   |  |
| 3. SEX<br>Female   | 4. RACE<br>White | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8/12/69   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>12 YRS.                            | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.   | IF UNDER 24 HRS.  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>1 5 1982                   | 2d. HOUR<br>P. M.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.              |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University Hospital - STU |   |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Student |   | 12b. KIND OF BUSINESS OR INDUSTRY            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Edward M. Murphy   |                  |   |   |  |   |  |   |  |
| 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Ramona Jane Trice   |                  |   | 13a. STREET ADDRESS<br>802 MacSherry Dr. 21012                        |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>no  |                  |   | 16b. SOCIAL SECURITY NO.<br>===                                       |  |   | 17. INFORMANT ADDRESS<br>Mr. and Mrs. Edward Murphy (same as 13e)        |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cervical Trauma</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |                  |   |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |                  |   |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |                  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                     |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                  |   | 21b. TIME OF INJURY<br>HOUR MONTH DAY YEAR<br>1:15 P.M. 1 5 1982      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>subject fell off parallel bars       |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |                  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>school |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>Peninsula Farm Rd. & Haverton Rd., Arnold, Anne Arundel Co., Md. |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                  |   |   |  |   |  |   |  |
| ACTUAL SIGNATURE<br>Virginia L. Dolan  |                  |   | TITLE (SPECIFY)<br>M.D. Assistant                                     |  |   | DATE SIGNED<br>1-6-82  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Virginia L. Dolan, M.D.  |                  |   | ADDRESS<br>111 Penn Street  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |                  |   | 23b. DATE<br>1/9/82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Glen Haven Memorial   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Glen Burnie A.A. Nathan               |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>George J. Gonce F.H. 4001 Ritchie Hgwy.  |                  |   |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 8 1982   |  |   |  |

NAVY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |   |   |   | 8 2 0 1 3 2 0  |  |
|--|---|---|---|--|--|
| 1- FOR STATE REGISTRAR   |   |   |   | REG. NO.   |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>Sallie Myers</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 28, 1982</b>                                  |  | 2b. HOUR<br><b>3:26P M</b>                   |
| 3 SEX<br><b>F</b>  | 4 RACE<br><b>C</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 19 06</b>  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b> YRS.                                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                     |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY            |
| 13a. STATE<br><b>md</b>  |   | 13b. COUNTY<br><b>Balto</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>501 Dolphin St</b>   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Malikai Grass</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Janine A-E</b>  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |   | 16b. SOCIAL SECURITY NO.<br><b>214-22-4270</b>  | 17. INFORMANT ADDRESS   |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrhythmia</b><br>4409<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Arteriosclerosis and</b><br>(c) <b>epileptic seizures</b>   |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a)   |   |   |   |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |   |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>January 28, 19 82</b> , to <b>January 28, 19 82</b> , that <input checked="" type="checkbox"/> (we) lost<br>saw the deceased alive on <b>January 28, 19 82</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated<br>above. <input type="checkbox"/> (we) did not view the body after death. |   |   |   |  |  |
| 22b. SIGNATURE<br><b>Walter Koppel</b>   |   | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>1/28/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Walter Koppel, M.D.</b>  |   | 22e. ADDRESS<br><b>c/o Maryland General Hospital</b>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |   | 23b. DATE<br><b>2/1/82</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Auburn</b>                              |  |
| 23d. LOCATION<br>(CITY OR TOWN)<br><b>Balto</b>  |   | COUNTY<br><b>MD</b>   |   | STATE  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Chas H. Powell</b>  |   | ADDRESS<br><b>F/H 319 N. Schroeder St</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 9 1982</b>                                   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>James J. Martin</b>   |   |   |   |  |  |

Chas. H. Rowell 11/18/1914  
Barrel 2 1/2 MT. Chlorine  
W.H. 11/18/1914

FOR  
1. STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 3 2 1

REG. NO.

|   |   |   |  |  |   |
|---|---|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Samuel Allen Naylor, Sr.</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Jan. 7, 1982</b>                         |  | 2b. HOUR<br><b>7:59 AM</b>  |
| 3. SEX<br><b>male</b>   | 4. RACE<br><b>white</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Jan. 5, 1906</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b> YRS.                                  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.              |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>          | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                  |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore City Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b> | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Bus Driver</b> |   |
| 13a. STATE<br><b>Maryland</b>   |   |   | 13b. COUNTY<br><b>-</b>  | 13c. CITY OR TOWN<br><b>Baltimore</b>                  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Henry Naylor</b> |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Alice Alverta Haines</b>       |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |   | 16b. SOCIAL SECURITY NO.<br><b>218-01-6800</b>  | 17. INFORMANT<br>ADDRESS <b>same as # 13</b><br><b>Ida June Naylor (wife)</b>      |  |   |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **Acute myocardial Infarction**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH**1-2 minutes**4100  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **ASCVD**

DUE TO, OR AS A CONSEQUENCE OF

(c)

**20 years**

## PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

① **Chronic obstructive pulmonary disease** ② **Diabetes mellitus**

|  |  |  |   |
|--|--|--|---|
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Feb 20</b> , 19 <b>80</b> , to <b>Nov 25</b> , 19 <b>81</b> , that (I) (we) last<br>saw the deceased alive on <b>Nov 25</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |   |
| 22b. SIGNATURE<br><b>[Signature]</b>   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED<br><b>11/8/82</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Iva A Morris M.D.</b>  | 22e. ADDRESS<br><b>2000 Odell Ave.</b>   |  |   |

|  |                                  |  |  |
|--|----------------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(CHECK) <b>Burial</b>       | 23b. DATE<br><b>Jan. 9, 1982</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Crest Lawn Cemetery</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Howard County, Maryland</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Raymond C. Fine</b>         |                                  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 8 1982</b>               | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                             |
| 24. FUNERAL HOME<br>NAME<br><b>Glen Burnie, Maryland 21061</b> |                                  |  |  |

( )



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH - 16 50M 1/B1  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 3 2 2

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |   |   |  |  |
|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>MARIE J. NEAL</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 23 82</b>   |  | 2b. HOUR<br><b>12:15</b> AM  |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec. 29, 1915</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b>  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>YRS.</b>                          |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>City</b> MD.   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>DEATON MEDICAL CENTER</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Trimmer Sewing</b>       | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Company</b>                                  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br><b>Md.</b>  | 13b. COUNTY<br><b>Balto.</b>  | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br><b>110 S. Randolph Rd.</b>                                    |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Samuel H. Neuhauser</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Josephine Ayres</b>   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>   |   | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT ADDRESS<br><b>Mr. William H. Neal Jr. same</b>                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b><br>0461<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <b>CRUETZFELDT-JACOB DISEASE</b><br>(c) <b>DUE TO, OR AS A CONSEQUENCE OF</b>                           |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>no</b>  |   |   |   |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>DEC. 28</b> , 19 <b>81</b> , to <b>JAN. 23</b> , 19 <b>82</b> , that (I) (we) lost<br>saw the deceased alive on <b>JAN. 23</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |   |   |   |  |  |
| 22b. SIGNATURE<br><b>William C. Davis</b>   |   | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>1/23/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DAVIS</b>   |   | 22e. ADDRESS<br><b>UNIVERSITY of MARYLAND Hospital</b>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   | 23b. DATE<br><b>Jan. 27, 1982</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Waugh Chapel</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Long Green Pike Balto. Md.</b>      |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J. Ruck Inc. Baltimore, Maryland</b>   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 25 1982</b>   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles J. Nathan</b>                               |  |

MEDICAL CERTIFICATION

UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT



UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 3 2 3

REG. NO.

|  |   |   |   |  |                                   |
|--|---|---|---|--|-----------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>George K. Nelms</b>   |   |   | 2a. DATE OF DEATH MONTH <b>1</b> DAY <b>22</b> YEAR <b>82</b>                                   |  | 2b. HOUR <b>10:55 AM</b>          |
| 3. SEX<br><b>MALE</b>  | 4. RACE<br><b>CAUCASIAN</b>   | 5. DATE OF BIRTH<br>MONTH <b>5</b> DAY <b>25</b> YEAR <b>13</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS.                                 |                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.              |                                   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore City</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>South Baltimore Gen. Hosp</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK OR MOST OF WORKING LIFE)<br><b>Bethlehem Steel</b>       |  | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE <b>Md.</b>  | 13b. COUNTY <b>Baltimore</b>  | 13c. CITY OR TOWN <b>Dundalk</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br><b>231 Parkwood Rd</b>                                  |                                   |
| 14. FATHER'S NAME<br>FIRST <b>William</b> MIDDLE <b>J.</b> LAST <b>NELMS</b>   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Annie</b> MIDDLE <b>Baughan</b> LAST <b>Baughan</b>        |  |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>230-07-0771</b>  |   | 17. INFORMANT<br><b>Helen Fisher-5212 Fir St, Waynesboro, Va.</b>              |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Failure - Massive pulmonary embolism.</b><br>2507<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Sepsis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Ulceration Right leg</b> |   |   |   |  |                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).<br><b>Diabetes Mellitus</b>   |   |   |   |  |                                   |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 19c. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |                                   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                   |
| 21a. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |   | 21b. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21c. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                   |
| 22. I certify that (1) this hospital attended the deceased from <b>1/6</b> 19 <b>82</b> to <b>1/22</b> 19 <b>82</b> that (1) (see item 18) above. (2) (yes) (did) (did not) view the body after death.   |   |   |   |  |                                   |
| 23a. SIGNATURE<br><b>Christopher Hookey MD</b>   |   | DEGREE <b>MD</b>  |   | 23c. DATE SIGNED<br><b>1/22/82</b>   |                                   |
| 23b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Christopher Hookey MD</b>  |   | 23d. ADDRESS  |   |  |                                   |
| 24a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>   |   | 24b. DATE<br><b>1-25-82</b>   |   | 24c. NAME OF CEMETERY OR CREMATORY<br><b>Augusta Memorial Park</b>             |                                   |
| 24d. FUNERAL DIRECTOR<br>NAME <b>McDow Funeral Home</b>  |   | ADDRESS <b>Waynesboro, Virginia</b>   |   | 25a. DATE RECEIVED BY REGISTRAR<br><b>JAN 27 1982</b>                          |                                   |
|  |   |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Frances Jan. Nathan</b>                       |                                   |

Virginia

William

J.

Archie

Benson

John Fisher-2012 21st, Winesboro, Va.

1-28

Colonel General Wm. Winesboro, Virginia  
1-28-2012 Augusta General Park Winesboro, Virginia

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be reprinted by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 707-4635.

## MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR   |  |   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 8 2 - 0 1 3 2 4  |  |  |  |
|--|--|---|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   |  | 2a. DATE OF DEATH   |  |  |  | 2b. HOUR   |  |  |  |
| FIRST MIDDLE LAST<br>Audrey Nelson   |  |   |  | MONTH DAY YEAR<br>1/2/82  |  |  |  | 10:00 P.M.   |  |  |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE   |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS.   |  |
| FEMALE   |  | B   |  | MONTH DAY YEAR<br>7 04 04   |  | 77 YRS.  |  | MONTHS DAYS  |  | HOURS MIN.   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |  |  |  |  |
| NO. Carolina   |  | USA   |  |   |  | BALTO. City MD.  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)               |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| Balto. City  |  | LUTHERAN Hosp.  |  |   |  | N/A  |  | N/A  |  |  |  |
| 13a. STATE   |  |   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?   |  | 13e. STREET ADDRESS  |  |
| Md.  |  |   |  |   |  | Balto.   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 2612 HARFORD ROAD  |  |
| 14. FATHER'S NAME  |  |   |  | 15. MOTHER'S MAIDEN NAME  |  |  |  |  |  |  |  |
| FIRST MIDDLE LAST<br>IKE LEWIS   |  |   |  | FIRST MIDDLE LAST<br>DEAL NELSON  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)   |  |   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS  |  |  |  |  |  |
| NO   |  |   |  | N/A   |  | DOLLIE RICHARDSON 1129 McALEER CT.   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>2765 IMMEDIATE CAUSE (a) Dehydration<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)  |  |   |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |   |  |   |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/25/81, 19____, to 1-2-82, 19____, that (I) (we) lost<br>saw the deceased alive on 1/2/82, 19____, and that (we) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  | 22b. SIGNATURE<br>S. W. March   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>1/2/82                                     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   |  | 22e. ADDRESS  |  |  |  |  |  |  |  |
| S. W. March  |  |   |  | Lutheran Hosp.  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  |   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |  |  |
| BURIAL   |  |   |  | 1/9/82  |  | BALTO. CEM.  |  | BALTIMORE MD.  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME   |  |   |  | 25a. DATE REC'D. BY REGISTRAR   |  |  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |
| W.C. MARCH F/H 1101 E. NORTH AVE.  |  |   |  | JAN 5 1982  |  |  |  | James J. Nathan  |  |  |  |



|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OF PRINT) FIRST MIDDLE LAST<br><b>EARLE CLIFTON (DIGGS) NELSON</b>   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>JAN 27, 1982</b>  |  | 2b. HOUR<br><b>M</b>  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>COL</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>FEB 10, 1914</b>  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b> YRS.  |  | 7. IF UNDER 1 YEAR MONTHS DAYS   |  | 7. IF UNDER 24 HRS. HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>BALTIMORE MD</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>  |  | 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>501 E. PRESTON ST. APT. 523</b>                |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  |
| 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>2815 BRESSMAN ST</b>   |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>THOMAS LUTHER NELSON</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>BEATRICE DIGGS</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>218-03 9970</b>   |  | 17. INFORMANT ADDRESS<br><b>Mrs Ada Hamilton 2815 BRESSMAN ST</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Coronary heart failure</b>   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  | 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  | 22a. I certify that (I) (this hospital) attended the deceased from <b>1-8</b> , 19 <b>81</b> , to <b>1-28</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>10-28</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE <b>S. Symm, MD</b> DEGREE  |  |
| 22c. DATE SIGNED<br><b>1-28-82</b>   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SUJETA SAPSIRI, MD</b>   |  | 22e. ADDRESS<br><b>1910-14 W. Pratt St, Baltimore, MD 21223</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>2-1-82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Auburn Cem</b>   |  |
| 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Westport Md.</b>   |  | 24. FUNERAL DIRECTOR NAME ADDRESS<br><b>Joseph L. Russ 2322 W. NORTH AVE</b>   |  | 25a. DATE REC'D. BY REGISTRAR 75b. REGISTRAR'S SIGNATURE<br><b>FEB 1 1982 Charles San Martin</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires: that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO : DIRECTOR, FBI (100-388610)

FROM : SAC, NEW YORK (100-100000) (P)

SUBJECT: [Illegible]

RE: [Illegible]

DATE: 1/9/71

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 3 2 6

REG. NO.

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>LIONEL HENRY NELSON</b>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>X 1 27 82</b>                                   |   | 2b. HOUR P<br><b>3:40 M</b>  |
| 3. SEX<br><b>MALE</b>  | 4. RACE<br><b>WHITE</b>  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>1 18 02</b>   |  | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>80</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Agnes Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Utility Man</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>General Motors</b>   |
| 13a. STATE<br><b>Maryland</b>  |  |   | 13b. COUNTY  | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>George</b>   |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Melinda Hoffman</b>                   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>213-10-4338</b>  |  | 17. INFORMANT ADDRESS<br><b>Mary Helen Nelson 2514 Southdene Avenue 21230</b>                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>5850 Cardio-respiratory arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Terminal stage of Chronic Renal Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                      |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Dr. A. Fort</b>   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                   |  | 22c. DATE SIGNED  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. A. Fort</b>  |  | 22e. ADDRESS  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>1/30/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b>   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>  |  | 23e. DATE REC'D. BY REGISTRAR<br><b>JAN 29 1982</b>   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Hubbard Funeral Home, Inc.</b>  |  | ADDRESS<br><b>4107 Wilkens Ave.</b>   |  | 25. REGISTRAR'S SIGNATURE<br><b>Thane J. [Signature]</b>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove this certificate to the State Department of Health and Mental Hygiene prior to burial, cremation, or other removal. Pages 1 and 2 should be filed within 7 days of death. Removal of this certificate after the funeral home has been notified by the funeral director, the medical examiner must be notified by the funeral home.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma event, the medical examiner must be notified by the funeral home.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |   | 8 2 0 1 3 2 7  |   |  |  |  |
|--|--|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  |   | REG. NO.   |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>James Nemphos</b>   |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>January 22, 1982</b>                              |   |  | 2b. HOUR <b>2 A. M.</b>  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>Jan. 25, 1925</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>56</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br><b>Baltimore, Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD.</b>                              |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>21 S. Linwood Avenue</b> |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Counter Clerk</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Resturant</b>    |  |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>----</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>21 S. Linwood Avenue</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>James H. Nemphos</b>   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Xanthi Janos</b>                        |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES OR UNKNOWN) <b>Yes</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAIVER DATES) <b>W W 11</b>  |  | 17. INFORMANT <b>Baltimore, Md. 21206.</b><br><b>George Nemphos-5830 Comstock Ave.</b>  |  |   |  |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>Ischemic heart disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Diabetes mellitus</b> |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>minutes</b><br><b>years</b>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>9 9</b>   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)           |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from <b>12 31</b> , 19 <b>81</b> , to <b>12 31</b> , 19 <b>81</b> , that (we) last saw the deceased alive on <b>12/31</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Steven P. Schuman</b>   |  |  |  |   | DEGREE<br><b>MD</b>  |   | 22c. DATE SIGNED<br><b>1/23/82</b>                       |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Steven P. Schuman</b>  |  |  |  |   | 22e. ADDRESS<br><b>601 W. Broadway Baltn</b>   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>1/25/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>                        |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>John A. Moran, Inc.</b><br>ADDRESS <b>3000 E. Baltimore St.</b>  |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 26 1982</b>                                      |   | 25b. REGISTRAR'S SIGNATURE<br><b>C. James Jan Nathan</b> |  |  |

James H. ...  
215-35-1123 George Washington ...  
Baltimore, Md. 21201

James H. ...  
Baltimore, Md. 21201

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |   |  |  |  |  |  |
|--|--|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  |   |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Evelyn Elizabeth Newport</b>  |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>1-8-82</b>  |  | 2b. HOUR<br>M <b></b>  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>9-12-18</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>63</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Tenn.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. City</b> MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3504 Parkside Drive</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret. Cashier</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>A&amp;P</b>  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   |  |  |  |  |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b></b>  |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>3504 Parkside Drive</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Don C. Newport, Sr.</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ruey E. Warden</b>  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>   |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>212-20-7588</b>  |  | 17. INFORMANT ADDRESS<br><b>Leta Mae Newport, 3504 Parkside Dr.</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br><b>2000</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Diffuse histiocytic Lymphoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 yr.</b><br><b>3-4 yrs.</b>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:   |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/14/81</b> , 19 <b>81</b> , to <b>12/17/81</b> , 19 <b>81</b> , that (I) (we) lost<br>saw the deceased alive on <b>12/17/81</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death.                  |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Naeem Gauhar</b>  |  |   |  | DEGREE<br><b>MD</b>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1/8/82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Naeem Gauhar, M.D.</b>   |  |   |  | 22e. ADDRESS<br><b>5400 Old Court Rd.</b>   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>1-11-82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto., Md.</b>   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J. Ruck, Inc., 5305 Harford Rd., Balto.</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 11 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Ginae Jean Parker</b>   |  |  |  |

100% COTTON FIBER



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                  |  |   |  |   |  |  |  | REG. NO. 2 0 1 3 2 9   |  |
|--|--|------------------|--|---|--|---|--|--|--|--|--|
| 1- FOR STATE REGISTRAR   |  |                  |  |   |  |   |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>CHARLES T. NORATEL   |  |                  |  |   |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR<br>1 13 19 82 |  | 2b. HOUR<br>8:45 P M   |  |  |  |
| 1. SEX<br>male   |  | 4. RACE<br>white |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>5 2 26   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>55 YRS.  |  | IF UNDER 1 YR. MONTHS DAYS   |  | IF UNDER 24 HRS. HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                       |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>824 W. Lombard St. |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Laborer   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Upholstery                                  |  |
| 13a. STATE<br>Md.  |  |                  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Balto.   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br>820 W. Lombard St.  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  |                  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br>Unkn.  |  |                  |  | (IF YES, GIVE WAR OR DATES)   |  | 16b. SOCIAL SECURITY NO.<br>216-20-3818   |  | 17. INFORMANT ADDRESS  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u><br>4292<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): |  |                  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                     |  |
| 19a. DATE OF OPERATION   |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .   |  |                  |  |   |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE <u>Ann M. Dixon</u>   |  |                  |  | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER   |  |   |  | DATE SIGNED 1-14-82  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.   |  |                  |  | ADDRESS 111 Penn St.  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal  |  |                  |  | 23b. DATE 1/19/82   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |
| 24. FUNERAL DIRECTOR NAME Anatomy Board ADDRESS Balto., Md.  |  |                  |  |   |  | 25a. DATE REC'D. BY REGISTRAR JAN 27 1982   |  | 25b. REGISTRAR'S SIGNATURE <u>James J. M. Nathan</u>   |  |  |  |

BP

Secretary  
Laborer

100 W. Lombard St.

100-10-1011

1011

1011-10-1011

1011-10-1011

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The certificate is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

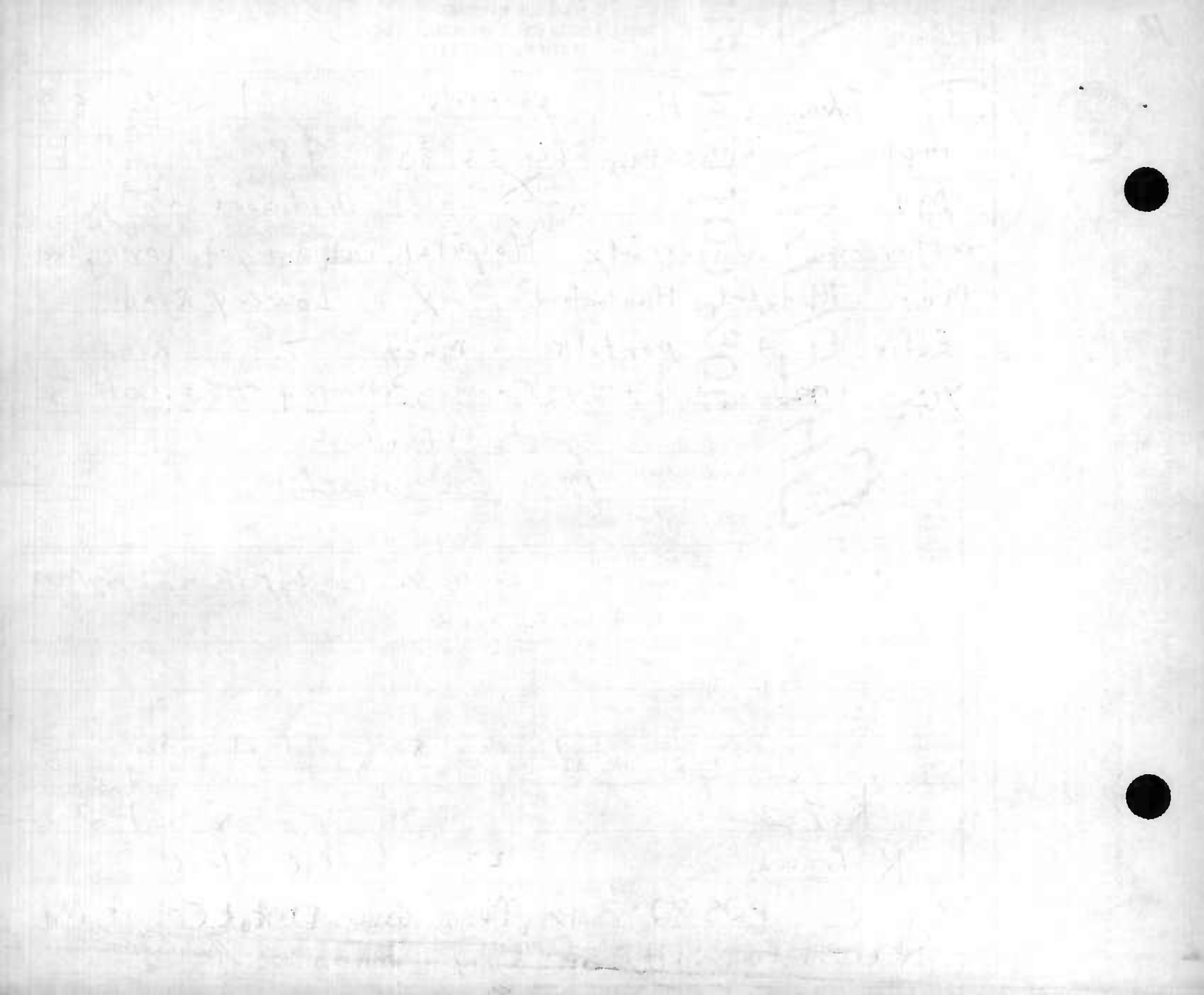
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| FOR<br>1- STATE<br>REGISTRAR   |  |   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 8 2 0 1 3 3 0  |  |   |  |
|--|--|---|--|--|--|--|--|--|--|---|--|
| CERTIFICATE OF DEATH   |  |   |  | REG. NO.   |  |  |  |  |  |   |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>Thomas H. Norfolk</b>  |  |   |  | 2a. DATE OF DEATH MONTH <b>1</b> DAY <b>21</b> YEAR <b>82</b>  |  |  |  | 2b. HOUR <b>5</b> <sup>PM</sup>  |  |   |  |
| 3 SEX <b>Male</b>  |  | 4 RACE <b>Caucasian</b>   |  | 5 DATE OF BIRTH MONTH <b>12</b> DAY <b>23</b> YEAR <b>33</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY) <b>48</b> YRS.                                      |  | IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>                                      |  | IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.                      |  |  |  |   |  |
| 10 CITY OR TOWN OF DEATH <b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University Hospital</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Self employed</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Knitting Machine</b>                        |  |   |  |
| 13a. STATE <b>Md.</b>  |  | 13b. CITY OR TOWN <b>Calvert</b>  |  | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS <b>Lowery Road</b>   |  |  |  |   |  |
| 14 FATHER'S NAME FIRST <b>Eddie</b> MIDDLE <b>A.</b> LAST <b>Norfolk</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST <b>Mary</b> MIDDLE <b>T.</b> LAST <b>King</b>   |  |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>  |  |   |  | 16b. SOCIAL SECURITY NO. <b>1954-1954-216302642</b>  |  | 17. INFORMANT <b>Geoffrey B Norfolk</b> ADDRESS <b>some, co #13</b>                |  |  |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac failure</b>   |  |   |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <b>Myocardial infarction</b>  |  |   |  |  |  |  |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |   |  |  |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Coronary artery Bypass grafts under cardiopulmonary Bypass.</b>  |  |   |  |  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION <b>1-21-82</b>  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Coronary Artery Disease</b>  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>           |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b> P.M.  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)    |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1-20-82</b> , to <b>1-21-82</b> , that (I) (we) lost saw the deceased alive on <b>1-21-82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death. |  |   |  |  |  |  |  |  |  |   |  |
| 22b. SIGNATURE <b>K. Prasad</b>  |  |   |  | DEGREE <b></b>   |  |  |  | 22c. DATE SIGNED <b>1-21-82</b>  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>K. Prasad</b>   |  |   |  | 22e. ADDRESS <b>22. S. Greene Street</b>   |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (TYPE) <b>Burial</b>   |  |   |  | 23b. DATE <b>1-25-82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Southern Maryland Cemetery</b>               |  | 23d. LOCATION CITY OR TOWN <b>Dunkirk</b> COUNTY <b>Calvert</b> STATE <b>Md.</b> |  |   |  |
| 24 FUNERAL DIRECTOR NAME <b>Ramona Funeral Home</b> ADDRESS <b>Awing</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>JAN 25 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>James G. [Signature]</b>                             |  |  |  |   |  |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove certain papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |  |  | 8 2 0 1 3 3 1  |           |                                       |                      |
|--|--|--|--|---|--|--|--|--|--|--|-----------|---------------------------------------|----------------------|
| 1- FOR<br>STATE<br>REGISTRAR   |  | REG. NO.   |  |   |  |  |  |  |  |  |           |                                       |                      |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST<br>Bessie  |  | MIDDLE  |  | LAST<br>Norman   |  | 2a. DATE OF DEATH  |  | MONTH<br>01  | DAY<br>25 | YEAR<br>82                            | 2b. HOUR<br>12:40 PM |
| 3. SEX<br>Female   |  | 4. RACE<br>Black   |  | 5. DATE OF BIRTH  |  | MONTH<br>12  |  | DAY<br>29  |  | YEAR<br>94   |           | 6. AGE (IN YEARS LAST BIRTHDAY)<br>87 |                      |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>VA.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Resident |  | 12b. KIND OF BUSINESS OR INDUSTRY  |           | MD.                                   |                      |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Provident                                     |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  | 13a. STATE<br>MD.  |  | 13b. COUNTY  |           | 13c. CITY OR TOWN<br>Baltimore        |                      |
| 14. FATHER'S NAME<br>William   |  | MIDDLE<br>Norman   |  | LAST<br>Katie   |  | 15. MOTHER'S MAIDEN NAME<br>Katie  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>224-18-1905  |           | 17. INFORMANT<br>Clarice Dorsey       |                      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u><br>4860<br>Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last.<br>(b) <u>Pneumonia</u><br>(c) <u>Acute Respiratory Infection</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>10 min |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1<br><u>Arteriosclerosis</u> |  | 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>    |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |           |                                       |                      |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  | 22a. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> |  | 22b. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)       |  | 22c. LOCATION<br>CITY OR TOWN COUNTY STATE   |           |                                       |                      |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 19, 1982</u> to <u>Jan 25, 1982</u> , that (I) (we) last saw the deceased <u>Jan 25, 1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.   |  | 22b. SIGNATURE<br><u>A. Miranda, MD</u>  |  | DEGREE  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                     |  | 22c. DATE SIGNED<br>1/25/82  |  |  |           |                                       |                      |
| 23a. PHYSICIAN'S NAME (TYPE OR PRINT)<br>A. MIRANDA, MD  |  | 23b. ADDRESS<br>Provident Hospital   |  | 24. BURIAL, CREMATION, REMOVAL<br>Burying   |  | 25. DATE<br>1/28/81  |  | 26. NAME OF CEMETERY OR CREMATORY<br>Westview Mem. Hk.                       |  | 27. LOCATION<br>City or Town County State<br>Baltimore County MD   |           |                                       |                      |
| 24. FUNERAL DIRECTOR<br>Name<br>Curry 1712 W. North Ave  |  | 25. DATE REC'D. BY REGISTRAR<br>JAN 26 1982  |  | 26. REGISTRAR'S SIGNATURE<br>Anne J. Gorman   |  |  |  |  |  |  |           |                                       |                      |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. GIVE PAGES 6 AND 7 TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP \_\_\_\_\_

DHMH - 17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |                  |  |   |   |   |  |   |   |  |  |
|---|------------------|--|---|---|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Clara May Nothey   |                  |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED<br>MONTH DAY YEAR<br>1 18 1982 |   |   | 2b. HOUR<br>M<br>3:10P<br>M  |   |   |  |  |
| 3. SEX<br>Female  | 4. RACE<br>White | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>April 6 1911   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>70 YRS.                       | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>1 18 1982                       | 2d. HOUR<br>M  |   |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Va   |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.  |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>218 N. Collington Avenue |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife    |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>household                                      |   |  |  |
| 13a. STATE<br>Md.   |                  | 13b. COUNTY<br>Balti.  |   | 13c. CITY OR TOWN<br>Baltimore  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 13e. STREET ADDRESS<br>218 N. Collington Ave. |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Unk   |                  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Unk                |   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No  |   |   | 16b. SOCIAL SECURITY NO.<br>224-14-4832      |  |
| 17. INFORMANT<br>James E. Nothey  |                  |  | ADDRESS<br>Same as 13   |   |   | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u><br>4292<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |                  |  |   |   |   |  |   |   |  |  |
| 19a. DATE OF OPERATION  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                   |   |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19          |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)         |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |   |   |  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |                  |  |   |   |   |  |   |   |  |  |
| ACTUAL SIGNATURE<br>Thomas D. Smith   |                  |  | TITLE (SPECIFY)<br>Deputy Chief                                     |   |   | MEDICAL EXAMINER<br>DATE SIGNED 1/19/82  |   |   |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Thomas D. Smith, M.D.  |                  |  | ADDRESS<br>111 Penn St. Balto., Md.                                 |   |   |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation  |                  |  | 23b. DATE<br>1-20-81  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview Crematory                      |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balt. Balt. Balt.                     |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Hardesty Funeral Home   |                  |  | ADDRESS<br>Annapolis, Md.   |   |   | 25a. DATE REC'D BY REGISTRAR<br>JAN 25 1982  |   | 25b. REGISTRAR'S SIGNATURE<br>Name            |  |  |

0603



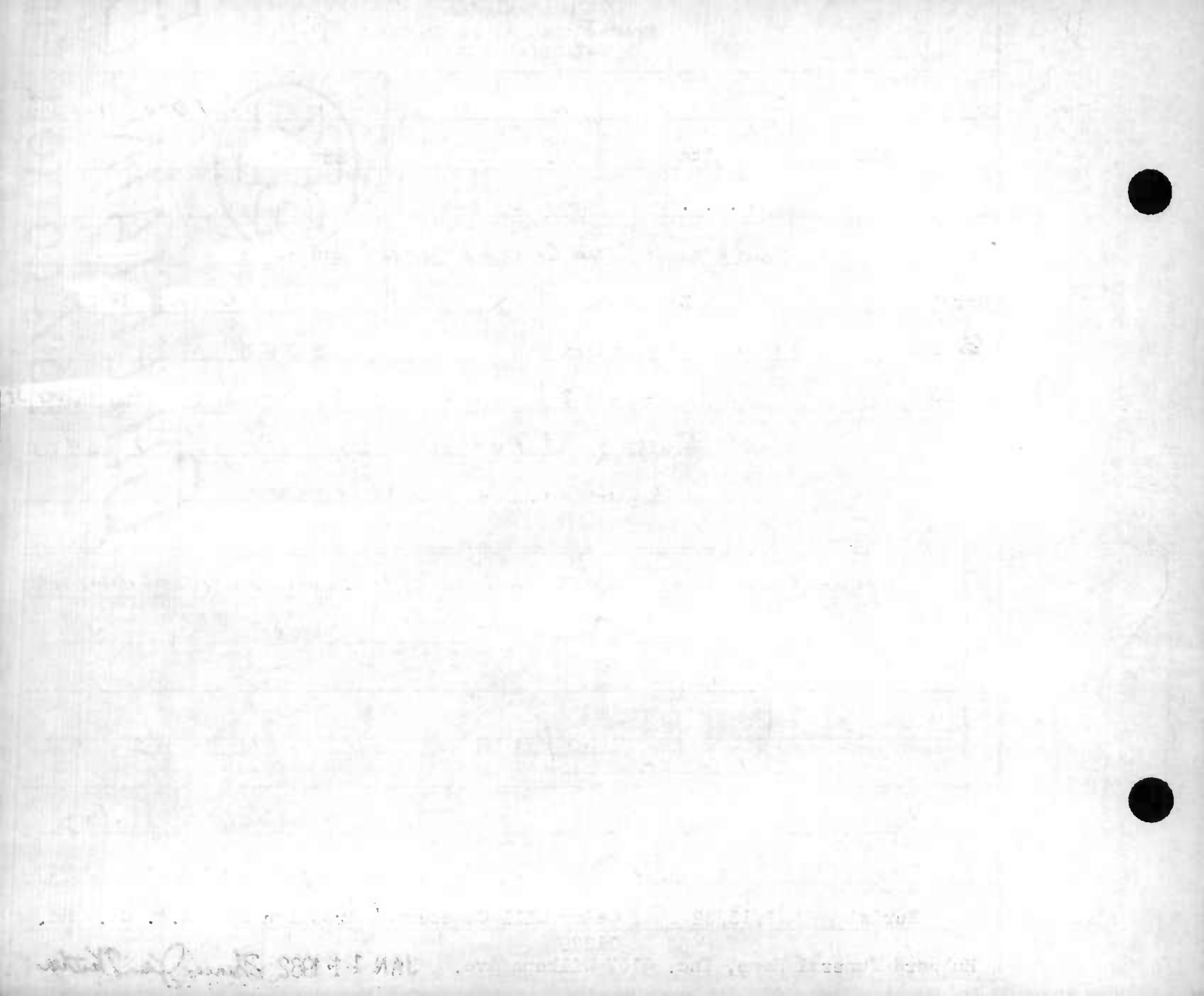


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |  |  |   |  |  |  | 8 2 0 1 3 3 3 |  |
|--|--|--|---|--|--|---|--|--|--|---------------|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO.   |   |  |  |   |  |  |  |               |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  |   |  | 2a. DATE OF DEATH  |   |  | 2b. HOUR   |  |               |  |
| FIRST MIDDLE LAST<br><b>CASIMIRA NOVACK</b>  |  |  |   |  | MONTH DAY YEAR<br><b>01-10-82</b>  |   |  | HOUR MIN.<br><b>1:20 AM</b>                                    |  |               |  |
| 3. SEX   |  | 4. RACE  |   | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR  |  |               |  |
| Female   |  | White  |   | MONTH DAY YEAR<br><b>2 16 93</b>   |  | 88 YRS  |  | MONTHS DAYS HOURS MIN.   |  |               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |               |  |
| Pennsylvania   |  | U.S.A.   |   |  |  | Baltimore City MD.  |  |  |  |               |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |               |  |
| Baltimore  |  | South Baltimore General Hospital   |   |  |  | Housewife   |  |  |  |               |  |
| 13a. STATE   |  | 13b. COUNTY  |   | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS  |  |               |  |
| Maryland   |  |  |   | Baltimore  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 1057 Church Street 21225                                       |  |               |  |
| 14. FATHER'S NAME  |  |  |   | 15. MOTHER'S MAIDEN NAME   |  |   |  |  |  |               |  |
| FIRST MIDDLE LAST<br><b>Pascal Rosolowski</b>  |  |  |   | FIRST MIDDLE LAST<br><b>UNKNOWN</b>  |  |   |  |  |  |               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  |  |  |   | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS   |  |  |  |               |  |
| NO   |  |  |   | 189-01-3482  |  | Pascal Bruza 1603 Inverness Avenue 21230                            |  |  |  |               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |  |  |   |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |               |  |
| PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Renal Failure</b>   |  |  |   |  |  |   |  |  | 1/6/82                                       |               |  |
| 5849 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Anemia + Hypothermia</b>  |  |  |   |  |  |   |  |  |  |               |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |   |  |  |   |  |  |  |               |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Severe Congestive heart Failure with superimposed pneumonia</b>  |  |  |   |  |  |   |  |  |  |               |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |               |  |
|  |  |  |   |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.                   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) |   |  |  |  |               |  |
|  |  |  | P.M. 19   |  |  |   |  |  |  |               |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |   |  |  |  |               |  |
|  |  |  |   |  |  |   |  |  |  |               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/28/81</b> , 19 <b>81</b> , to <b>1/10</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>1/9/82</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |  |  |   |  |  |  |               |  |
| 22b. SIGNATURE <b>Olga Melender, M.D.</b>  |  |  |   |  | DEGREE   |   |  | 22c. DATE SIGNED <b>1/10/82</b>                                |  |               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Olga Melender, M.D.</b>   |  |  |   |  | 22e. ADDRESS <b>3001 S. Hanover St. Balt. MD.</b>                              |   |  |  |  |               |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION CITY OR TOWN COUNTY STATE            |  |  |               |  |
| Burial   |  |  | 1/13/82   |  | Cedar Hill Cemetery  |   | Brooklyn Pk A.A. Co. Md.                           |  |  |               |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS <b>Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229</b>  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE <b>James J. Thorton</b> |  |  |               |  |
|  |  |  |   |  | JAN 11 1982  |   |  |  |  |               |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 3 3 4

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>James Odom   |  |   | 2a. DATE OF DEATH<br>January 23, 1982                                      |   | 2b. HOUR<br>8:12A M  |
| 3. SEX<br>M   | 4. RACE<br>Black   | 5. DATE OF BIRTH<br>3 25 1910   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>71 YRS.                                 | IF UNDER 1 YEAR<br>MONTHS DAYS  | IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Barnwell, S.C.   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                 |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Maryland General Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Welder | 12b. KIND OF BUSINESS OR INDUSTRY<br>Bethlehem Steel  |  |
| 13a. STATE<br>Md.   |  | 13b. COUNTY   | 13c. CITY OR TOWN<br>BALTO   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>1701 EUTAW PL.  |
| 14. FATHER'S NAME<br>Joseph Odom  |  | 15. MOTHER'S MAIDEN NAME<br>Elizabeth Williams  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.  | 17. INFORMANT<br>Athe'lla CARTER 6526 Wyncote Phila, Pa.                   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Apparent Myocardial Infarction</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>30 Minutes |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from December 19, 1981, to January 23, 1982, that (X) (we) lost saw the deceased alive on January 23, 1982, and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (do not) view the body after death.   |  |   |  |   |  |
| 22b. SIGNATURE<br>Robert Ammlung  |  | DEGREE<br>MD  |  | 22c. DATE SIGNED<br>1/23/82   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Robert Ammlung, M.D.   |  | 22e. ADDRESS<br>c/o Maryland General Hospital   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>1-29-82  | 23c. NAME OF CEMETERY OR CREMATORY<br>Fairview Cern.                       |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Willow Grove PA  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Jas. A. MORTON & SONS   |  | ADDRESS<br>1701 LAURENS ST.   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 25 1982  |  |
|   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br>Charles J. Nathan   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

15814-10116-000



Handwritten notes and text, mostly illegible due to extreme fading and bleed-through from the reverse side of the page. Some visible fragments include "U.S. A.", "W. H. A.", and "15814-10116-000".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |   |  |  |  |  |  | 8 2 0 1 3 3 5  |  |
|---|--|---|--|---|--|--|--|--|--|--|--|
| 1 - STATE REGISTRAR   |  |   |  |   |  |  |  |  |  | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Margaret A. Oehm</b>   |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1/31/82</b>  |  | 2b. HOUR<br><b>11:30 PM</b>  |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12-30-1926</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>55</b> YRS   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                      |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br><b>Balto, Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Agnes Hosp.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>book</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Restaurant</b>                               |  |  |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>1928 Deering Ave 21230</b>                                 |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Michael M. Dorsey</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE<br><b>Mary E. Wetzel</b>   |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>213-20-7907</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Mr Robert A. Mibo Jr. above</b>  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CoPD,</b><br><b>2780</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Morbid obesity.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1-18-82</b> , to <b>1-31-82</b> , that (I) (we) last saw the deceased alive on <b>1-31-82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.        |  |   |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>A. Mathis</b>  |  |   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1-31-82</b>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>A. Mathis</b>   |  |   |  |   |  | 22e. ADDRESS<br><b>St. Agnes Hospital - Baltimore.</b>   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |   |  | 23b. DATE<br><b>2/4/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>London Park Cem.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>                   |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>John J. Cowen Int.</b>   |  |   |  |   |  | ADDRESS<br><b>22 Hollins St.</b>   |  | 25. DATE REC'D. BY REGISTRAR<br><b>FEB 2 1982</b>                                    |  | 26. REGISTRAR'S SIGNATURE<br><b>James J. [Signature]</b>   |  |



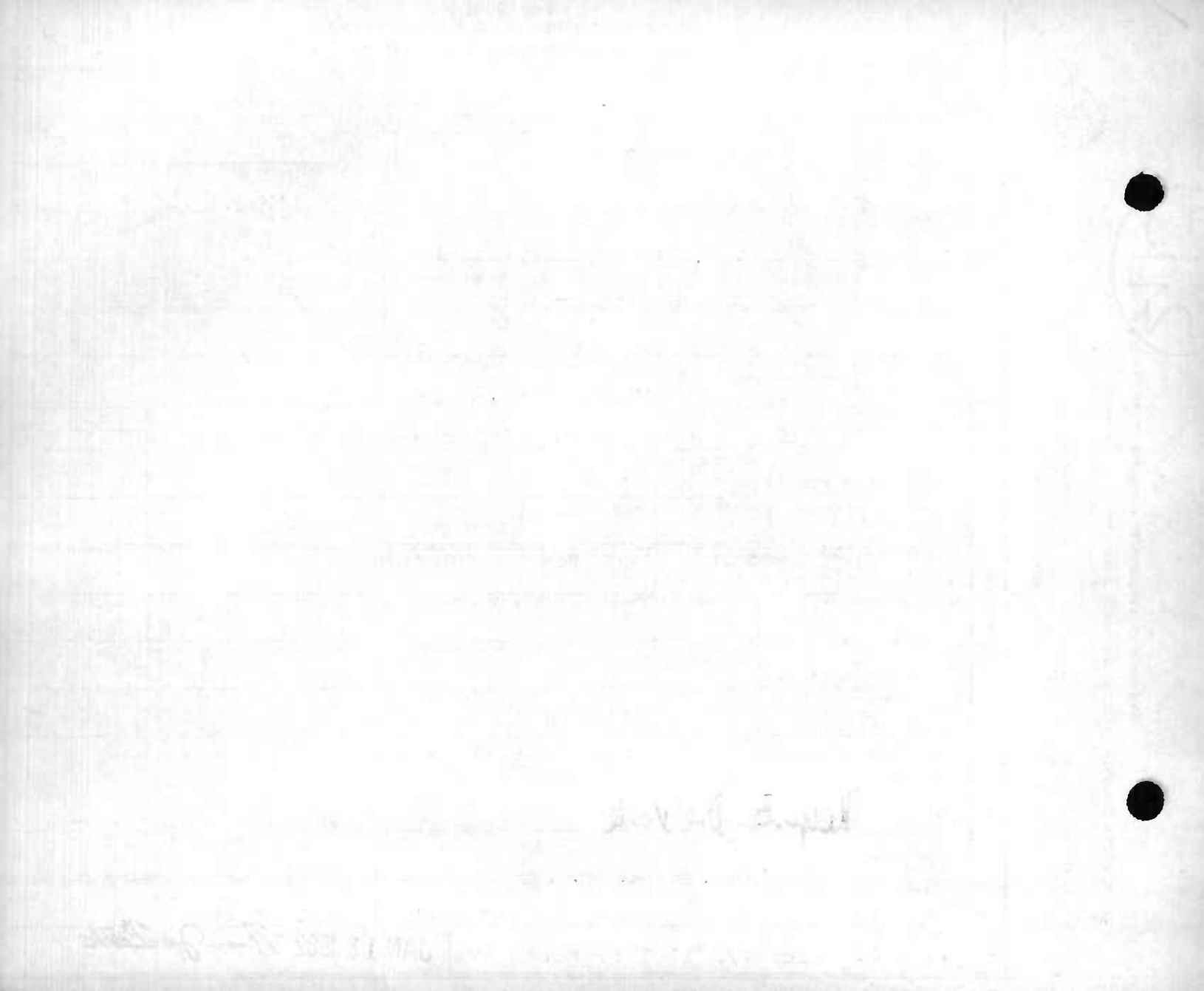


**NOTES TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE ADVISE THE CHIEF OF MEDICAL EXAMINATION BY TELEPHONE OR IN WRITING. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. PAGES 3 AND 4 SHOULD BE FORWARDED TO THE CHIEF OF MEDICAL EXAMINATION ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. **NOTES TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |                         |  |        |   |   |   |   |   |   |   |  |
|--|-------------------------|--|--------|---|---|---|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>CASPER</b>   |                         | FIRST  | MIDDLE | LAST<br><b>W. OGLESBY</b>   |   | 2a. DATE KNOWN OF DEATH<br>MONTH DAY YEAR<br><b>X8 1-14-829</b>                                 |   | 7b. HOUR<br>M<br>P<br><b>2:50</b>   |   |   |  |
| 3. SEX<br><b>male</b>  | 4. RACE<br><b>black</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 10 1912</b>  |        | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69 YRS.</b>                             | IF UNDER 1 YR.<br>MONTHS DAYS<br><b>69</b>  |   | IF UNDER 24 HRS.<br>HOURS MIN.<br><b>69</b>                         |   | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>1-14-829</b> |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>S. C.</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |        |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>       |   |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>618 St. Anns Street</b> |        |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                   |   | 12b. KIND OF BUSINESS OR INDUSTRY   |   |   |  |
| 13a. STATE<br><b>Md</b>  |                         | 13b. COUNTY  |        | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>618 St Anns Street</b>                                    |   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Henry Oglesby</b>   |                         |  |        | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Izelia</b>                |   |   |   |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br><b>No</b>  |                         | 16b. SOCIAL SECURITY NO.<br><b>247-30-2720</b>   |        | 17. INFORMANT<br>ADDRESS<br><b>Bessie L. Oglesby</b>                          |   |   |   |   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br><b>4960 IMMEDIATE CAUSE (a) chronic obstructive pulmonary disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |                         |  |        |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |   |   |  |
|  |                         |  |        |   |   |   |   |   |   |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><b>metastatic cardinoma</b>   |                         |  |        |   |   |   |   |   |   |   |  |
| 19a. DATE OF OPERATION   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |        |   |   |   |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |   |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |   |   |   |   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |        | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |   |   |   |   |   |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                         |  |        |   |   |   |   |   |   |   |  |
| ACTUAL SIGNATURE<br><b>Margarete PreKrell</b>  |                         | TITLE (SPECIFY)<br><b>M.D. Assistant MEDICAL EXAMINER</b>  |        |   |   |   |   | DATE SIGNED<br><b>1-15-82</b>   |   |   |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Margarita A. Koroll, M.D.</b>  |                         | ADDRESS<br><b>11 Penn Street</b>   |        |   |   |   |   |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |                         | 23b. DATE<br><b>1/21/82</b>  |        | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview Mem Park</b>                |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Catonsville Md</b> |   |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>William C. March F/H 1101 E. North Ave</b>  |                         |  |        | 25a. DATE REC'D BY REGISTRAR<br><b>JAN 18 1982</b>                            |   |   |   |   |   | REGISTRAR'S SIGNATURE<br><b>[Signature]</b> |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 3 3 7

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>George W. Oliver</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 13 82</b>  |  | 2b. HOUR<br>MIN.<br><b>956 A</b>   |
| 3. SEX<br><b>MALE</b>  | 4. RACE<br><b>W HITE</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 20 14</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b> YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NEW YORK</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. City</b> MD.   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Sinai Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>MERCHANT</b>  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>RETAIL</b>                                   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE CITY OR TOWN<br><b>MARYLAND BALTO. BALTO.</b>  |  |  | 13b. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>XXX</b>                                 |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ALEXANDER OLIVER</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ROSE UNKNOWN</b>   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(IF UNKNOWN)<br><b>YES</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>212-09-7755</b>   | 17. INFORMANT<br>ADDRESS<br><b>MRS. MAXINE OLIVER</b><br><b>37 STONEHENGE CIR., APT. 7 #21208</b>  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause 101, stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19 82 1/13 82</b>  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/13 82</b> to <b>1/13 82</b> , that (I) (we) last saw the deceased alive on <b>1/13 82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>C. Levin</b>  |  | DEGREE<br><b>MD</b>  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED<br><b>1/13/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>C. LEVIN</b>   |  | 22e. ADDRESS<br><b>Sinai Hospital</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>JAN 15 1982</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BETH TFILOH</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b>  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b><br><b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>   |  |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>JAN 20 1982</b>   |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the vital records office after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

5

4

ISSN 0013-788X

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 3 3 8

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|   |  |  |  |  |  |   |  |  |  |  |  |
|---|--|--|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ESTHER</b>   |  | FIRST <b>ESTHER</b>  |  | MIDDLE   |  | LAST <b>OSTRY</b>   |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>1 24 82</b>                                |  | 2b. HOUR <b>7:37</b>                             |  |
| 3. SEX <b>Female</b>  |  | 4. RACE <b>W HITE</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>9 9 05</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS  |  | IF UNDER 24 HRS. HOURS MIN.                      |  |
| 7a. BIRTH PLACE (STATE OR FOREIGN COUNTRY) <b>RUSSIA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO CITY</b> MD   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>BALTO CITY</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>LEVINSON GERIATRIC HOSP.</b> |  |  |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b> |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>MARYLAND</b>  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN <b>BALTO CITY</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  | 13e. STREET ADDRESS <b>APT. C-10 #21215</b>                                    |  | 13f. <b>3612 LABYRINTH RD</b>                    |  |
| 14. FATHER'S NAME FIRST <b>ISAAC</b> MIDDLE LAST <b>BORINSKY</b>  |  | 15. MOTHER'S MAIDEN NAME FIRST <b>ROSE</b> MIDDLE LAST <b>MARGOLIN</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>  |  | 16b. SOCIAL SECURITY NO. <b>217-07-5464</b>   |  | 17. INFORMANT <b>MR. BURT A. ADAMS</b>   |  | 17b. <b>3600 LABYRINTH RD., APT. K-20 #21215</b> |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <b>Cancer of colon &amp; rect</b><br><b>1539</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ |  |  |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/10</b> 19 <b>81</b> to <b>1/24</b> 19 <b>82</b> , that (we) lost saw the deceased alive on <b>1/24</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (do not) view the body after death.   |  |  |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE <b>N.D. LIST</b>   |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 22c. DATE SIGNED <b>1/24/82</b>   |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS <b>Greenspring &amp; Belvidere Av 2114</b>  |  |  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>   |  | 23b. DATE <b>JAN. 26, 1982</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>OHEL YAKOV</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>   |  |  |  |  |  |
| 24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., INC.</b> NAME ADDRESS <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>   |  | 25a. DATE REC'D. BY REGISTRAR <b>JAN 27 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Frances Jan Nathan</b>   |  |   |  |  |  |  |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 3 3 9

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Susan L. Oswinkle   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1 28 82  |  | 2b. HOUR<br>10:13 AM   |
| 3. SEX<br>F   | 4. RACE<br>W   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4 13 50   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>31 YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>                           |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                          |  |
| 10. CITY OR TOWN OF DEATH<br>Balto., Md.  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Hospital, Deering Ave., Balto., Md. 21230 |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Md. Medical Laboratory      |  | 12b. KIND OF BUSINESS OR INDUSTRY                                |
| 13a. STATE<br>Md.   |  | 13b. CITY OR TOWN<br>Balto.   | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>2019 Deering Ave., Balto., Md. 21230                          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Louis A. Clauss   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Katherine Critzman   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT<br>ADDRESS<br>Louis A. Clauss Balto., Md. 21230                        |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>METASTATIC CARCINOMA OF CERVIX</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>MALNUTRITION</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>1809<br>3 YRS.<br>2 YEARS<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><u>SPONTANEOUS ABDOMINAL FISTULA FORMATION</u>  |  |   |   |  |  |
| 19a. DATE OF OPERATION<br>—   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>—   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>— — — 19 —   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br>—  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>—   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>— — — — —                       |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10-3</u> , 19 <u>81</u> , to <u>1-28</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>1-19</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |  |  |
| 22b. SIGNATURE<br><u>Soon Ja Kim, MD</u>  |  | DEGREE<br>M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/><br>DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br>1/30/82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>SOON JA KIM, MD</u>   |  | 22e. ADDRESS<br><u>4713 LEEDS AVE. ARBUTUS, MD 21227</u>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><u>Burial</u>   |  | 23b. DATE<br><u>2-1-82</u>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Meadowridge Mem. Park</u>                   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Balto. Md.</u>   |  |   |   |  |  |
| 24. FUNERAL DIRECTOR<br><u>G. Norman Schwab, P.A.</u>   |  | 25a. DATE REC'D. BY REGISTRAR<br><u>FEB 2 1982</u>  |   | 25b. REGISTRAR'S SIGNATURE<br><u>Soon Ja Kim</u>                                     |  |
| 24. FUNERAL HOMES<br><u>Funeral Homes</u>   |  | 25c. ADDRESS<br><u>3522 Frederick Ave., 21229</u>   |   |  |  |

MEDICAL CERTIFICATION

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  | REG. NO.  |  |
|--|--|--|--|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  |  |  | 7. DATE OF DEATH   |  |  |  | 7b. HOUR  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>MARSHALL B. OURSLER  |  |  |  |  |  | 1/19/82  |  |  |  | 12:35 AM  |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>Cauc  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>1 15 04   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>78  |  | 8. IF UNDER 1 YEAR MONTHS DAYS   |  | 9. IF UNDER 24 HRS. HOURS MIN.  |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                   |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>So. Baltimore General Hosp |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Dairy Worker                |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Koontz  |  |   |  |
| 13a. STATE<br>Md   |  | 13b. COUNTY<br>A.A. Co.  |  | 13c. CITY OR TOWN<br>Brooklyn  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>5315 Fourth Street  |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Enzor   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Madeline Orem  |  |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO  |  |  |  | 16b. SOCIAL SECURITY NO.<br>216 10 4853  |  | 17. INFORMANT ADDRESS<br>Richard B. Oursler 5216 4th Street                                  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4275 cardiopulmonary arrest<br>DUE TO, OR AS A CONSEQUENCE OF (b) pulmonary emboli a myocardial infarction<br>DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)               |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br>Joseph P. Grant  |  |  |  | DEGREE   |  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>1/19/82   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Joseph L Grant  |  |  |  | 22e. ADDRESS<br>3001 S. Hanover St   |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>1/22/82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Glen Haven Mem Pk  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Glen Burnie A.A. Md.                              |  |  |  |   |  |
| 24. FUNERAL DIRECTOR NAME<br>George J. Gonc  |  |  |  | 24b. ADDRESS<br>4001 Ritchie Hgwy  |  | 25a. DATE REC'D BY REGISTRAR<br>JAN 20 1982  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |   |  |

BP



Items #1a-22a Film G565 3/3/82 STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 2 0 1 3 4 1

1- STATE REGISTRAR  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO.

|  |                         |   |  |   |   |  |   |  |
|--|-------------------------|---|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Terry Lee Owen</b>  |                         |   | 20. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>1 14 1982</b> |   |   | 2b. HOUR <b>M</b>  |   |  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>12 23 48</b>  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <b>33</b> YRS.  | IF UNDER 1 YR.<br>MONTHS DAYS   | IF UNDER 24 HRS.<br>HOURS MIN.  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR <b>1 15 1982</b>        | 2d. HOUR <b>8:25 A.M.</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Ohio</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City,</b> MD. |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>135 N. Bradford Street</b> |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Laborer</b>                 |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><b>Maryland</b>  |                         |   | 13b. COUNTY<br><b>---</b>  | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>102 North Kresson Street</b>             |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Raymond Lee Owen</b>  |                         |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Gladys Juanita Hamilton</b>                          |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES/NO, OR UNKNOWN)<br><b>Yes</b>   |                         | 16b. SOCIAL SECURITY NO.<br><b>216-50-3015</b>  |  | 17. INFORMANT ADDRESS<br><b>Robert G. Owen 102 N. Kresson Street</b>  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Intravenous Narcotism</b><br><b>3049</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |                         |   |  |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1   |                         |   |  |   |   |  |   |  |
| 19a. DATE OF OPERATION   |                         |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                         |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                         |   |  |   |   |  |   |  |
| ACTUAL SIGNATURE<br><b>Virginia L. Dolan</b>   |                         |   | TITLE (SPECIFY)<br><b>Assistant</b>  |   |   | DATE SIGNED<br><b>1-16-82</b>                                      |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Virginia L. Dolan, M.D.</b>   |                         |   | ADDRESS<br><b>111 Penn Street</b>  |   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |                         |   | 23b. DATE<br><b>1-19-82</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn Cemetery</b>                                  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Eastwood Balto. Co. Md.</b>        |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>C.S. Zeiler &amp; Son Inc.</b>  |                         |   | ADDRESS<br><b>6224 Eastern Avenue</b>  |   |   | 25a. DATE RECD. BY REGISTRAR<br><b>JAN 19 1982</b>                 |   |  |
|  |                         |   |  |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Thomas J. [Signature]</b>         |   |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1, 2, AND 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 3 4 2

FOR  
STATE  
REGISTRAR

REG. NO.

|  |   |   |  |   |  |
|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>HATTIE M. PACE</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JANUARY 7, 1982</b>                  |   | 2b. HOUR<br><b>8:28A<sup>M</sup></b>   |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>Black</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 15 03</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b>  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>YRS.</b>   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>South Carolina</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                                       |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(INDOT IN FACTORY, CARE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b> |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD</b> 13b. COUNTY <b>BALTIMORE</b> 13c. CITY OR TOWN <b>Baltimore</b> 13d. INSIDE CITY LIMITS? <b>YES</b> <input type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS <b>2033 Sinclair Lane</b>  |   |   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charlie Williams</b>  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Josephine Williams</b>     |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>267-05-8769</b>  |  | 17. INFORMANT ADDRESS<br><b>Maley Pace 2033 Sinclair Lane</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b><br>1809<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Cervical Cancer</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8:28am</b>                      |   |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |   |   |  |   |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/5</b> , 19 <b>82</b> , to <b>1/7</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>1/7/82</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |   |  |   |  |
| 22b. SIGNATURE<br><b>Claire M. West</b>  |   | DEGREE  |  | 22c. DATE SIGNED<br><b>1/7/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CLAIRE M. WEST MD</b>  |   | 22e. ADDRESS<br><b>JOHNS HOPKINS HOSPITAL</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  | 23b. DATE<br><b>1/11/82</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Garden of Eter. Hope</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Westminister MD</b>                                    |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H, Inc. 1101 E. North Ave.</b>   |   |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 8 1982</b> REGISTRAR'S SIGNATURE<br><b>James J. [Signature]</b> |  |

MEDICAL CERTIFICATION

may be retained by the hospital or attending physician.  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should be detached for use as the burial-transit permit. Then please remove the two papers. Pages 1 and 2 should be filed within 10 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1910-1911



RECEIVED

1910-1911



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with in 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 8 2 0 1 3 4 3   |  |  |   |
|---|--|--|--|---|--|--|---|
| FOR<br>1. STATE<br>REGISTRAR  |  |  |  | REG. NO.  |  |  |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>RUSSIE E. PACE</b>   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>1/7/82</b>  |  |  |   |
| 3. SEX <b>F Female</b>  |  |  |  | 2b. HOUR <b>530 A.M.</b>  |  |  |   |
| 4. RACE <b>W White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>9/12/25</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>56</b>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balt city</b>  |   |
| 10. CITY OR TOWN OF DEATH <b>Balt Md</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore City Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Home maker</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>   |   |
| 13a. STATE <b>Maryland</b>  |  |  |  | 13b. COUNTY <b>-----</b>  |  |  |   |
| 13c. CITY OR TOWN <b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS <b>125 S. Ann Street</b>  |  |  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>Frederick Schectlein</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Mary Bell Taylor</b>   |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>no</b>  |  | 16b. SOCIAL SECURITY NO. <b>-----</b>  |  | 17. INFORMANT ADDRESS <b>Baltimore, Md/ 21231</b><br><b>Sylvia Jean Harmon 213 S. Register Street</b>   |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardio-pulm Arrest</b><br><b>3340</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Friedrichs Ataxia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>years</b>                                 |  |  |  |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>no</b>  |  |  |  |   |  |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>              |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |   |
| 22a. SIGNATURE <b>Jay R. Schachner</b>  |  |  |  | DEGREE <b>MD</b>  |  | 22c. DATE SIGNED <b>1/7/82</b>   |   |
| 22a. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JAY Schachner</b>  |  |  |  | 22e. ADDRESS <b>116 W Univ. Pkwy Balt. Md</b>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>  |  | 23b. DATE <b>Jan 10, 82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>Davis, West Virginia</b>   |   |
| 24. FUNERAL DIRECTOR<br>NAME <b>Doppel Funeral Homes, Inc.</b> ADDRESS <b>7110 Belair Road Baltimore, Md.</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>JAN 8 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>James J. Nathan</b>  |   |

[illegible]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGES 1 AND 2 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |                         |   |  |   |   |  |  |   |   |  |
|--|-------------------------|---|--|---|---|--|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Earl A Pachilis</b>  |                         |   | 2a. DATE KNOWN OF DEATH<br>MONTH DAY YEAR<br><b>1 31 19 82</b>               |   |   | 2b. HOUR<br>M<br><b>4:25 PM</b>  |  |   |   |  |
| 3. SEX<br><b>male</b>  | 4. RACE<br><b>white</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>JAN. 14 1953 27</b>  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY YRS.<br><b>27</b>                         | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.<br><b>0 0 0 0</b>  | IF UNDER 24 HRS.<br>HOURS MIN.<br><b>0 0</b>              | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>1 31 19 82</b>  |  |   | 7d. HOUR<br>M<br><b>4:25 PM</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD.</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>  |  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Eastern Ave &amp; Haven Street</b> |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)<br><b>Const. Worker</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>TELEPHONE</b>           |   |  |
| 13a. STATE<br><b>MD.</b>   |                         |   | 13b. COUNTY<br><b>BALTO.</b>   |   | 13c. CITY OR TOWN<br><b>BALTO.</b>                        |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |   | 13e. STREET ADDRESS<br><b>2521 EASTERN AVE.</b>          |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles W. Pachilis</b>   |                         |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Dolores Lukasik</b>      |   |   |  |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>   |                         |   | 16b. SOCIAL SECURITY NO.<br><b>72-78 213-62-2328</b>                         |   | 17. INFORMANT<br><b>Dolores Rites</b>                     |  |  | ADDRESS<br><b>SAME 21224</b>                                    |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Multiple injuries</b><br>8120<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF  |                         |   |  |   |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |                         |   |  |   |   |  |  |   |   |  |
| 19a. DATE OF OPERATION   |                         |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                            |   |   |  |  |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                         |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>4:17 PM 1/31 19 82</b> |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>driver in auto/tractor trailer collision</b> |  |   |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |                         |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>street</b> |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>Eastern Ave &amp; Haven St, Baltimore City, MD</b>                       |  |   |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquest <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                         |   |  |   |   |  |  |   |   |  |
| ACTUAL SIGNATURE<br><b>Margarita A. Korell</b>   |                         |   | TITLE (SPECIFY)<br><b>Assistant</b>  |   |   | MEDICAL EXAMINER   |  |   | DATE SIGNED<br><b>2/1/82</b>  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Margarita A. Korell, M.D.</b>   |                         |   | ADDRESS<br><b>111 Penn Street, Baltimore, MD 21201</b>                       |   |   |  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |                         |   | 23b. DATE<br><b>2-4-82</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>OAKLAWN CEM.</b> |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO. MD.</b> |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>THOMAS J. SKARDA</b>  |                         |   |  |   |   | ADDRESS<br><b>2829 HUDSON ST.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 3 1982</b>              |   | 25b. REGISTRAR'S SIGNATURE<br><b>Anna J. [Signature]</b> |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 8 2 0 1 3 4 5   |  |   |   |
|---|--|--|--|---|--|---|---|
| FOR<br>1. STATE<br>REGISTRAR  |  |  |  | CERTIFICATE OF DEATH  |  |   |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  |  | 2a. DATE OF DEATH   |  |   |   |
| FIRST Tyhessia MIDDLE S. LAST Page<br>BABY GIRL (SPENCER)   |  |  |  | MONTH DAY YEAR<br>1 21 82   |  | 2b. HOUR<br>1 P.M.  |   |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>BLACK   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1 20 82   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS MONTHS DAYS<br>1 1   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALT. CITY MD.  |   |
| 10. CITY OR TOWN OF DEATH<br>BALT.  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>JOHN A. MD. |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |   |
| 13a. STATE<br>MARYLAND  |  |  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore  |   |
| 14. FATHER'S NAME<br>FIRST Tyhessia MIDDLE S. LAST Page   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST GLORIA MIDDLE SPENCER LAST  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>N/A  |  | 17. INFORMANT<br>ADDRESS<br>Lidia Spencer 924 N. Rosedale St.   |  |   |   |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>7798 IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) —<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) —<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br>POSSIBLE SEPSIS |  |  |  |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/21, 1982, to 1/21, 1982, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |   |
| 22b. SIGNATURE<br>Eric D. Berman  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                   |  | 22c. DATE SIGNED<br>1/21/82   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ERIC D. BERMAN   |  |  |  | 22e. ADDRESS<br>UNIVERSITY OF MARYLAND HOSPITAL   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>1/27/82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cem.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. Co. MD   |   |
| 24. FUNERAL DIRECTOR<br>Wm. C. March F/H 1101 E. North Ave.   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 25 1982  |  |   |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 3 4 6

REG. NO.

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>FRANCES PALMER</b>   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 6 82</b>  |  | 2b. HOUR<br><b>9<sup>30</sup> AM</b>  |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 28 37</b>  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>South Carolina</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore City</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University Hospital</b> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD.</b>   |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Dietary Assistant</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Nursing home</b>  |  |   |  |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>—</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore City</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Allen</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elizabeth Allen</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>219-60-3926</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>JANINE PALMER SAME</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b><br>4275<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>UNKNOWN</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 hour</b> |  |   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Hypertension, Asthma, Anemia</b>   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (this hospital) attended the deceased from <b>JANUARY 19 76</b> , to <b>1/6 19 82</b> , that (we) lost<br>saw the deceased alive on <b>1/6 19 82</b> , and that in (my) <del>my</del> opinion death occurred on the date and hour and from the causes stated<br>above, (I) <del>did</del> (did not) view the body after death.  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>David S. Prince MD</b>   |  | DEGREE  |  | 22c. DATE SIGNED<br><b>1/6/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DAVID S. PRINCE MD</b>  |  | 22e. ADDRESS<br><b>University of Maryland Hospital</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>1/12/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Allen A.M.E.</b>   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore South Can.</b>   |  | 23e. DATE REC'D. BY REGISTRAR<br><b>JAN 11 1982</b>   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leroy O. Dyett</b>   |  | ADDRESS<br><b>4600 Liberty Hgts.</b>  |  | 25. REGISTRAR'S SIGNATURE<br><b>James J. [Signature]</b>  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requirement that the deceased be exsanguinated within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please reattach to the original record. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified to investigate.

DHMH - 16 50M 1/81  
(VRA 15, 4)

RELEASED NON-MED DR. SMITH PER MR. HENRY

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |   |   |   |  |  |  |
|--|--|--|--|---|---|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  |   | 8 2 0 1 3 4 7   |   |  |  |  |
| CERTIFICATE OF DEATH   |  |  |  |   | REG. NO.  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JAMES W. PALMER JR.</b>   |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>JANUARY 18, 1982</b>                                     |   |  |  |  |
| 3 SEX <b>MALE</b>  |  |  |  |   | 2b. HOUR <b>6:08PM</b>  |   |  |  |  |
| 4 RACE <b>NEGRO</b>  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR <b>10 17 08</b>  |  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS<br>HOURS MIN.                |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>A.A.I.C. MD</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD. |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b>                     |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK OR MOST OF WORKING LIFE)<br><b>Retired</b>               |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD</b> 13b. COUNTY <b>BALTIMORE</b> 13c. CITY OR TOWN <b>BALTIMORE</b>  |  |  |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>1400 E. MADISON ST 916</b>   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>JAMES W PALMER SR</b>  |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>BURGLIA DUKIN</b>                              |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS<br><b>Thelma Palmer 1400 E. Madison St 916</b>  |   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiac arrest.</b><br>1629<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Lung Cancer</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |  |  |   |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |  |  |  |   |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER).  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>6:30 PM 1/18/82</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>Johns Hopkins Hosp</b>  |   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/18/82</b> , to <b>19</b> , that (I) (we) lost<br>saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                       |  |  |  |   |   |   |  |  |  |
| 22b. SIGNATURE<br><b>W. J. Kaley</b>   |  | DEGREE <b>MD</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   | 22c. DATE SIGNED<br><b>1-18-82</b>  |   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>W. J. Kaley</b>  |  | 22e. ADDRESS<br><b>JHH</b>   |  |   |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>BURIAL</b>   |  | 23b. DATE<br><b>1/23/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MO. AUSTIN</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MD</b> |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Thelma Palmer</b> ADDRESS <b>638 N. G. / M. W. ST</b>  |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR<br><b>JAN 20 1982</b>                              |   |  |  |  |

THE UNIVERSITY OF CHICAGO  
LIBRARY  
JANUARY 1900  
[Faint, mostly illegible handwritten text follows, appearing to be a list or index of items.]



TO HOSPITAL OR ATTENDING PHYSICIAN: The low **01/24/02** retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



DHMH-16 30M 2/BO  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1 - FOR  
STATE  
REGISTRAR

|  |  |  |  |  |  |   |  |  |  |
|--|--|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST MIDDLE LAST  |  | 2a. DATE OF DEATH  |  | MONTH DAY YEAR  |  | 2b. HOUR   |  |
| BABY BOY   |  | PARHAM   |  | JANUARY 27, 1982   |  | 9:32  |  | M  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | 7. IF UNDER 1 YEAR   |  |
| Male   |  | Black  |  | 1/24/82  |  | YRS. MONTHS DAYS  |  | 7  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  | 10. IF UNDER 24 HRS.   |  |
| Baltimore, Md.   |  | U.S.A.   |  |  |  | BALTIMORE CITY  |  | MD   |  |
| 11. CITY OR TOWN OF DEATH  |  | 12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 13a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 13b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |
| Baltimore, Md.   |  | JOHNS HOPKINS HOSPITAL   |  |  |  |   |  |  |  |
| 14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE ADDRESS BEFORE ADMISSION)  |  | 14a. STATE   |  | 14b. COUNTY  |  | 14c. CITY OR TOWN   |  | 14d. INSIDE CITY LIMITS?   |  |
| Md.  |  | Md.  |  | Baltimore  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 14e. STREET ADDRESS  |  |
| 14f. FATHER'S NAME   |  | 14g. MOTHER'S MAIDEN NAME  |  | 14h. FATHER'S NAME   |  | 14i. MOTHER'S MAIDEN NAME   |  | 14j. FATHER'S NAME   |  |
| D. J. R. R.  |  | M. C. H. E. D.   |  | D. J. R. R.  |  | M. C. H. E. D.  |  | D. J. R. R.  |  |
| 15a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 15b. SOCIAL SECURITY NO.   |  | 15c. INFORMANT   |  | 15d. ADDRESS  |  | 15e. ADDRESS   |  |
| NO   |  |  |  | Theresa Parham   |  | 7030 K. L. St.  |  | Baltimore, Md.   |  |
| 16. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:  |  | 16a. IMMEDIATE CAUSE (a)   |  | 16b. DUE TO, OR AS A CONSEQUENCE OF  |  | 16c. DUE TO, OR AS A CONSEQUENCE OF                                 |  | 16d. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                  |  |
| 7690   |  | Hypoxia  |  | Respiratory Distress Syndrome  |  | Prematurity   |  |  |  |
| 17. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)            |  | 17a. DATE OF OPERATION   |  | 17b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 17c. AUTOPSY?   |  | 17d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?     |  |
| None   |  | N/A  |  | N/A  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>           |  |
| 18a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 18b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 18c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)   |  | 18d. DATE SIGNED  |  | 18e. DATE SIGNED   |  |
|  |  | P.M. 19  |  |  |  | 1/27/82   |  | 1/27/82  |  |
| 19a. INJURY OCCURRED   |  | 19b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 19c. LOCATION  |  | 19d. CITY OR TOWN   |  | 19e. COUNTY  |  |
| While <input type="checkbox"/> Not While <input type="checkbox"/>  |  | At Home  |  | Johns Hopkins Hospital   |  | Baltimore   |  | Md.  |  |
| 20a. I certify that (I) (this hospital) attended the deceased from   |  | 20b. I certify that (I) (this hospital) attended the deceased from                                     |  | 20c. I certify that (I) (this hospital) attended the deceased from   |  | 20d. I certify that (I) (this hospital) attended the deceased from  |  | 20e. I certify that (I) (this hospital) attended the deceased from |  |
| Jan 27, 1982   |  | Jan 27, 1982   |  | Jan 27, 1982   |  | Jan 27, 1982  |  | Jan 27, 1982   |  |
| 21a. SIGNATURE   |  | 21b. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 21c. ADDRESS   |  | 21d. DATE SIGNED  |  | 21e. DATE SIGNED   |  |
| Karen R. Kingery   |  | KAREN R. KINGERY   |  | Johns Hopkins Hospital   |  | 1/27/82   |  | 1/27/82  |  |
| 22a. BURIAL, CREMATION, REMOVAL  |  | 22b. DATE  |  | 22c. NAME OF CEMETERY OR CREMATORY   |  | 22d. LOCATION   |  | 22e. COUNTY  |  |
| Burial   |  | 1/27/82  |  | Mt. Auburn Cemetery  |  | Baltimore   |  | Md.  |  |
| 23a. FUNERAL DIRECTOR  |  | 23b. DATE REC'D. BY REGISTRAR  |  | 23c. REGISTRAR'S SIGNATURE   |  | 23d. DATE REC'D. BY REGISTRAR                                       |  | 23e. REGISTRAR'S SIGNATURE   |  |
| C. J. Carroll  |  | FEB 4 1982   |  | Theresa Parham   |  | FEB 4 1982  |  | Theresa Parham   |  |



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RECEIVED  
01/11/88

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 3 4 9

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ALBERTA M. PARKER</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1-6-82</b>  |  | 2b. HOUR<br><b>10:34 PM</b>                      |
| 3. SEX<br><b>FEMALE</b>   | 4. RACE<br><b>BLACK</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 3 1898</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>83</b> YRS.                                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VIRGINIA</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                    |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Johns Hopkins Medical Center</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>HOME</b> |
| 13a. STATE<br><b>MARYLAND</b>   | 13b. COUNTY  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>1810 APPLETON STREET</b><br><b>BALTIMORE, MARYLAND</b>     |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>THOMAS</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>HARRIETT STITCH</b>   |   | 16. ADDRESS<br><b>MARYLAND 21216</b>   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>213-01-44290</b>   |   | 17. INFORMANT<br><b>MRS. LOUISE P. BLACKWELL</b> ADDRESS<br><b>3000 ELGIN AVENUE</b> |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>C.V.A. - Cardiac Arrest</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>A.S.C.U.D.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>8 Months</b><br><b>10 years</b> |  |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____   |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/4/82</b> to <b>1/6/82</b> , that (I) (we) lost<br>saw the deceased alive on <b>1/4/82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |   |   |  |  |
| 22b. SIGNATURE<br><b>Paul Schonfeld MD</b>  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |   | 22c. DATE SIGNED<br><b>1/7/82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Paul Schonfeld</b>  |  | 22e. ADDRESS<br><b>407 Chain Highway Glen Burnie</b>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   | 23b. DATE<br><b>1/11/82</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Abnatus Memorial Park</b>  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE COUNTY, MARYLAND</b>                 |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>BALTA MD. 21216</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 11 1982</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>James J. [Signature]</b>                            |  |
| Nutter Funeral Home 3055 W. NORTH AVE.  |  |   |   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

CONFIDENTIAL

CONFIDENTIAL





FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 3 5 0

REG. NO.

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>Beulah I. PARKER</b>   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1-11-82</b>  |  | 2b. HOUR<br><b>2:58</b> M  |  |
| 3 SEX<br><b>Female</b>  |  | 4 RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov. 23, 1895</b>                           |  |
| 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b> YRS.  |  | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore, City</b> MD   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(LIST IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>John L. Deaton Md Center</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |  |
| 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |  |  |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>-</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Herbert McCauley</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Katherine Bollinger</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>no</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>215 50 8406</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Robert R. Parker Same</b>                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of colon metastases</b><br><b>1539</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>H.O. Congestive heart failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br><b>Pressure ulcers</b><br>APPROPRIATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Dec. 17</b> , 19 <b>81</b> , to <b>Jan 11</b> , 19 <b>82</b> , that (I) (we) lost<br>saw the deceased alive on <b>Jan 11</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Julian W. Reed M.D.</b>  |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>1/13/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JULIAN W. REED M.D.</b>   |  | 22e. ADDRESS<br><b>611 S. CHAS. ST. BALTO MD 21201</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>1/14/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge Cemetery</b>                    |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Pikesville, Balto, Maryland</b>  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Burgess Funeral Home 3631 Falls Road 21211</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 18 1982</b>  |  |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>James J. [Signature]</b>   |  |  |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1-11-33 27

Deputy I. J. [unclear]

|                 |             |              |             |
|-----------------|-------------|--------------|-------------|
| Home            | White       | Nov. 2, 1933 | 25          |
| Address         | 1111        | 1111         | 1111        |
| City            | St. Louis   | St. Louis    | St. Louis   |
| State           | Mo.         | Mo.          | Mo.         |
| Occupation      | Officer     | Officer      | Officer     |
| Age             | 21          | 21           | 21          |
| Height          | 5' 10"      | 5' 10"       | 5' 10"      |
| Weight          | 150         | 150          | 150         |
| Complexion      | Light       | Light        | Light       |
| Hair            | Dark        | Dark         | Dark        |
| Eyes            | Blue        | Blue         | Blue        |
| Build           | Medium      | Medium       | Medium      |
| Marital Status  | Single      | Single       | Single      |
| Education       | High School | High School  | High School |
| Religion        | Catholic    | Catholic     | Catholic    |
| Political Party | Dem.        | Dem.         | Dem.        |
| References      | None        | None         | None        |

1/11/33  
St. Louis, Mo.  
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1111

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. PAGES 1, 2, AND 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                         |  |  |   |   |   |  |   |  | REG. NO. 2 0 1 3 5 1 |  |
|--|-------------------------|--|--|---|---|---|--|---|--|----------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>JASON PARKER</b>   |                         |  |  |   |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>1-21-82</b> |  | 2b. HOUR<br><b>11:08 P.M.</b>   |  |                      |  |
| 3. SEX<br><b>male</b>  | 4. RACE<br><b>black</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>NOV 4 1962</b>  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY YRS.<br><b>19</b>                         | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.<br><b>19</b>   | IF UNDER 24 HRS.<br>HOURS MIN.<br><b>19</b>   | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>1-21-82</b>  |  |   |  |                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>US of A</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  |   |  |                      |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2598 Druid Park Drive</b> |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>CARPENTER</b>                         |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>JOB CORPS</b>                               |  |                      |  |
| 13a. STATE<br><b>MARYLAND</b>  |                         | 13b. COUNTY<br><b>BALTIMORE</b>  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           |  | 13e. STREET ADDRESS<br><b>3426 HILDALE PLACE</b>                                    |  |                      |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ROBERT LEE PARKER</b>   |                         |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ALBERTEAN ALLEN</b>      |   |   |   |  |   |  |                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>NO</b>   |                         | 16b. SOCIAL SECURITY NO.<br><b>? ?</b>   |  | 17. INFORMANT ADDRESS<br><b>MR. ROBERT L. PARKER 3426 HILDALE PL.</b>   |   |   |  |   |  |                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Stabwound to chest</b><br>9660<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF   |                         |  |  |   |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                      |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |                         |  |  |   |   |   |  |   |  |                      |  |
| 19a. DATE OF OPERATION   |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                            |   |   |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                      |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>? 1-21-82 19</b>       |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>subject stabbed</b> |   |  |   |  |                      |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>street</b> |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>? Baltimore, Maryland</b>                       |   |  |   |  |                      |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                         |  |  |   |   |   |  |   |  |                      |  |
| ACTUAL SIGNATURE<br><b>Margarita A. Korell</b>   |                         |  | TITLE (SPECIFY)<br><b>M.D. Assistant</b>                                     |   |   | MEDICAL EXAMINER  |  |   | DATE SIGNED<br><b>1-22-82</b>                |                      |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Margarita A. Korell, M.D.</b>  |                         |  | ADDRESS<br><b>111 Penn Street</b>  |   |   |   |  |   |  |                      |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |                         |  | 23b. DATE<br><b>1/26/82</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MT. AUBURN CEMETERY</b>  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE</b>                      |  |                      |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>LEWIS T. GWYNN 4517 PARK HEIGHTS AVENUE</b>   |                         |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 27 1982</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Howe Jan Parker</b> |   |  |                      |  |



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3450 HILLMAN BLVD

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MR. ROBERT L. GARRON 3450 HILLMAN BLVD

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1/26/82

RECEIVED

THOMAS T. O'NEAL 4517 PARK HILLMAN AVENUE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |  |  | REG. NO.   |  |
|--|--|---|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Mildred D. Parker   |  |   |  |   |  | 2a. DATE OF DEATH<br>January 9, 1982   |  |  |  | 2b. HOUR<br>4:45 PM  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>April 9, 1923   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>58  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                     |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Belair Convalesarium |  |   |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>Maryland   |  |   |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Baltimore   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br>6918 Old Harford Road   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>George Rammes  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Marie Gerhardt   |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(IF YES, GIVE WAR OR DATES)<br>No  |  |   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br>Edward M. Parker 6918 Old Harford Road                        |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>3453 IMMEDIATE CAUSE (a) STATUS EPILEPTICUS<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) SEIZURE DISORDER<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 hr<br>YEARS: 74               |  |   |  |   |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>Slow Alzheimer's Disease; Complicated multiple Pneumonia; Recurrent Urinary Infection.  |  |   |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART 1 OR PART 2) |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |  |  |
| 22a. I certify that (I) <del>the hospital</del> attended the deceased from 12/5/81 to 1/11/82, that (I) <del>(we)</del> lost<br>saw the deceased alive on 12/5/81, and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated<br>above, (I) <del>(we)</del> (did not) view the body after death. |  |   |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br>Albert B. Bradley  |  |   |  |   |  | DEGREE<br>MD   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>1/11/82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Albert B. Bradley M.D.  |  |   |  |   |  | 22e. ADDRESS<br>4900 Belair Road Baltimore, Maryland                           |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |   |  | 23b. DATE<br>Jan. 13, 1982  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Oak Lawn                                 |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland  |  |  |  |
| 24. FUNERAL DIRECTOR<br>Leonard J. Ruck, Inc. Baltimore, Maryland  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 11 1982                                   |  |  |  |  |  |

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*[Handwritten signature]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 233-1234.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |  |  |  |  |     |  |  |  |                                   |  |
|--|--|--|--|--|--|--|--|-----|--|--|--|-----------------------------------|--|
| CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |     |  |  |  |                                   |  |
| REG. NO.   |  |  |  |  |  |  |  |     |  |  |  |                                   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  | 2a. DATE OF DEATH  |  |  | MONTH  |  | DAY |  | YEAR   |  | 2b. HOUR                          |  |
| Pierce   |  |  | Parker, Sr.  |  |  | January  |  | 11, |  | 1982   |  | 1:15p M                           |  |
| 3. SEX   |  |  | 4. RACE  |  |  | 5. DATE OF BIRTH   |  |     | 6. AGE (IN YEARS LAST BIRTHDAY)                                |  |  | 7. IF UNDER 1 YEAR                |  |
| Male   |  |  | Black  |  |  | 30 Oct. 22   |  |     | 59   |  |  | MONTHS DAYS HOURS MIN             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |     | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |  |  |                                   |  |
| Va.  |  |  | U. S. A.   |  |  |  |  |     | Baltimore City MD.   |  |  |                                   |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  |  |     | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| Baltimore  |  |  | Maryland General Hospital  |  |  |  |  |     | Laborer  |  |  | --0-----                          |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  | 13b. CITY OR TOWN  |  |  | 13c. INSIDE CITY LIMITS?   |  |     | 13d. STREET ADDRESS  |  |  |                                   |  |
| Md.  |  |  | Baltimore  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |     | 109 Oak St. 21222  |  |  |                                   |  |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |     |  |  |  |                                   |  |
| Afford Parker  |  |  | Irene  |  |  |  |  |     |  |  |  |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  | 16b. SOCIAL SECURITY NO.   |  |  | 17. INFORMANT ADDRESS  |  |     |  |  |  |                                   |  |
| Yes  |  |  | C-5444415  |  |  | 220-05-2228 Pierce Parker Jr. 1505 Cavalier Blvd.  |  |     |  |  |  |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |  |  |     |  | 19. EXAMINE INTERVAL (HOURS) ONSET AND DEATH |  |                                   |  |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |  |  |  |  |     |  | Portsmouth, Va. 23701                        |  |                                   |  |
| IMMEDIATE CAUSE (a)  |  |  |  |  |  |  |  |     |  | Minutes                                      |  |                                   |  |
| 4310 DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |  |  |     |  |  |  |                                   |  |
| (b) Intracerebral bleed secondary to   |  |  |  |  |  |  |  |     |  |  |  |                                   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |     |  |  |  |                                   |  |
| (c) malignant hypertension.  |  |  |  |  |  |  |  |     |  |  |  |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:   |  |  |  |  |  |  |  |     |  |  |  |                                   |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?  |  |     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |                                   |  |
|  |  |  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |     | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |  |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |     |  |  |  |                                   |  |
|  |  |  | P.M. 19  |  |  |  |  |     |  |  |  |                                   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |     |  |  |  |                                   |  |
|  |  |  |  |  |  |  |  |     |  |  |  |                                   |  |
| 22a. I certify that (X) (this hospital) attended the deceased from January 4, 19 82, to January 11, 19 82, that (X) (we) last saw the deceased alive on January 11, 19 82, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |     |  |  |  |                                   |  |
| 22b. SIGNATURE   |  |  | DEGREE   |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |  |     | 22c. DATE SIGNED   |  |  |                                   |  |
| Robert Ammlung   |  |  | M.D.   |  |  |  |  |     | 1/11/82  |  |  |                                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  | 22e. ADDRESS   |  |  |  |  |     |  |  |  |                                   |  |
| Robert Ammlung, M.D.   |  |  | c/o Maryland General Hospital  |  |  |  |  |     |  |  |  |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  | 23b. DATE  |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |     | 23d. LOCATION CITY OR TOWN COUNTY STATE                        |  |  |                                   |  |
| Burial   |  |  | 1/18/82  |  |  | Crownsville St VA  |  |     | Crownsville, Maryland  |  |  |                                   |  |
| 24. FUNERAL DIRECTOR NAME  |  |  | 25a. DATE RECEIVED BY FUNERAL HOME   |  |  | 25b. DATE RECEIVED BY REGISTRAR  |  |     |  |  |  |                                   |  |
| Law Funeral Home 4611 Park Heights Ave.  |  |  | JAN 18 1982  |  |  | James J. Smith   |  |     |  |  |  |                                   |  |





The General Store, 111 and 112th Ave

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed in the office of the health department within 24 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called for an autopsy.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |   |   |  |  |   |  |  |  |  |
|--|--|--|---|---|--|--|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Mattie Virginia Parks</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1/16/82</b>                         |   | 2b. HOUR<br><b>7:05 P.M.</b>   |  |   |  |  |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4/27/13</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b>   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br>YRS.   |  | 8. IF UNDER 24 HRS.<br>HOURS MIN.            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Calvert Co. MD</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>South Baltimore General Hospital</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>retired</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>towing co.</b>   |  |  |  |
| 13a. STATE<br><b>MD</b>  |  |  | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>                                    |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1512 Covington St.</b> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Albert ----- Parks</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Florence ----- Dorsey</b> |   |  |  |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>219-22-2585</b>                                |   | 17. INFORMANT<br>ADDRESS<br><b>Mr. Reese C. Parks, Sr. Same as above</b> |  |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>aspiration pneumonia</b><br><b>5672</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>sepsis</b><br>(c) <b>retroperitoneal abscess</b>                                  |  |  |   |   |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>Abdominal Abscesses sepsis</b>  |  |  |   |   |  |  |   |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>12/30/81</b>  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>abdominal abscess</b>  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY OFFICE, FARM, ETC.)         |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Jan. 16</b> , 19 <b>82</b> , to <b>January</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>Jan 16</b> , 19 <b>82</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |   |   |  |  |   |  |  |  |  |
| 22b. SIGNATURE<br><b>Michael Louis Richey</b>  |  |  | DEGREE  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |  | 22c. DATE SIGNED<br><b>1/16/82</b>               |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Michael Louis Richey</b>   |  |  | 22e. ADDRESS<br><b>3001 S. Hanover Baltimore MD</b>                           |   |  |  |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>Jan. 20, 1982</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b>         |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>                        |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>McCutty Funeral Home, 130 E. Fort Ave. Balto. Md.</b>   |  |  |   |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 19 1982</b>  |   |  |  |  |  |
|  |  |  |   |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>James J. [Signature]</b>  |   |  |  |  |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                      |   |  |  |                  |   |  |   |  | REG. NO. 01355                               |  |
|--|----------------------|---|--|--|------------------|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>WOODROW Wilson Parlett</b>  |                      |   |  |  |                  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> <b>1-28-82</b> |  | 2b. HOUR <b>AM</b>  |  |  |  |
| 3. SEX <b>male</b>   | 4. RACE <b>white</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>Apr. 28 1918</b>  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>63 YRS.</b> | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.   | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD <b>1-28-82</b>   |  | 2d. HOUR <b>3:50 PM</b>   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>  |                      | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.  |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |                      | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>4522 Arabia Avenue</b> |  |  |                  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Stock Clerk</b>                              |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| 13a. STATE <b>Maryland</b>   |                      | 13b. COUNTY   |  | 13c. CITY OR TOWN <b>Baltimore</b>   |                  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                  |  | 13e. STREET ADDRESS <b>Balt., Md. 21214</b>   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>Daniel H. Parlett</b>  |                      | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Pauline Miller</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>   |                  |   |  |   |  |  |  |
|  |                      |   |  | 16b. SOCIAL SECURITY NO.   |                  | 17. INFORMANT <b>Brother: Carroll C. Parlett</b> ADDRESS <b>Balt., Md. 21213</b>                              |  |   |  |  |  |
|  |                      |   |  |  |                  | 2614 E. Oliver St.  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Chronic obstructive pulmonary disease</b><br>4960<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF  |                      |   |  |  |                  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |                      |   |  |  |                  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |                      |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |                  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                      |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                 |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |                      |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |                  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |                      |   |  |  |                  |   |  |   |  |  |  |
| ACTUAL SIGNATURE <i>Margarita A. Koroll</i>  |                      |   |  | TITLE (SPECIFY) <b>M.D. Assistant</b>  |                  |   |  | DATE SIGNED <b>1-29-82</b>  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Koroll, M.D.</b>   |                      |   |  | ADDRESS <b>111 Penn Street</b>   |                  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |                      |   |  | 23b. DATE <b>Feb 2 1982</b>  |                  | 23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>                |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS <b>Leonard J. Ruck, Inc. Baltimore, Maryland</b>  |                      |   |  |  |                  | 25a. DATE REC'D. BY REGISTRAR <b>FEB 1 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE <i>Shane Jan North</i>                                   |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 8 2 0 1 3 5 6   |  |  |  |  |  |
|--|--|--|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  | REG. NO.  |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>Leathia Viola Parran   |  |  | 2a. DATE OF DEATH<br>January 12, 1982                                  |   |  | 2b. HOUR<br>M  |  |  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>Black   |  | 5. DATE OF BIRTH<br>12 <sup>TH</sup> 6 <sup>AY</sup> 06 <sup>EAR</sup>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>75 YRS  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1912 N. Homewood Ave. |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)               |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD   |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Richard Parran   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Rose Green  |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>217-09-3595   |  | 17. INFORMANT ADDRESS<br>Melviner Worrell 2816 Baker St.  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Hypertension</u><br>4029<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>ASCVD</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last           |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 yrs<br>2 yrs |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/16/80</u> 19 <u>80</u> , to <u>1/12/82</u> 19 <u>82</u> , that (I) (we) lost<br>saw the deceased alive on <u>1/12/82</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><u>Amatur N. Naeem</u>   |  |  | DEGREE<br>MD   |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>1/14/82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>541 Delpia St, Balto MD</u>  |  |  | 22e. ADDRESS<br><u>Amatur N. Naeem</u>                                 |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |  | 23b. DATE<br>1/18/82   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Auburn Cem.                          |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore MD     |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H   |  |  | ADDRESS<br>1101 E. North Ave.  |   |  | 25a. DATE REC'D BY REGISTRAR<br>JAN 18 1982  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Amatur N. Naeem</u>   |  |





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

82 01357

FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |                                    |  |   |   |  |
|---|--|--|------------------------------------|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST MIDDLE LAST  |                                    | 2a. DATE OF DEATH MONTH DAY YEAR   |   | 2b. HOUR P M  |  |
| EVELYN B. PARRISH   |  |  |                                    | January 20, 1982   |   | 6:00 P  |  |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH MONTH DAY YEAR  |                                    | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.   |   | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.   |  |
| Female  | White  | May 11, 1900   |                                    | 81   |   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9. BALTIMORE CITY OR COUNTY OF DEATH MD.   |   |   |  |
| Maryland  | USA  |  |                                    | Baltimore City   |   |   |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                                    | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| Baltimore   | Long Green Nursing Center  |  |                                    | Teacher  |   | Education   |  |
| 13a. STATE  |  | 13b. COUNTY  | 13c. CITY OR TOWN                  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS                     |   |  |
| Maryland  |  |  | Baltimore                          |  | 2833 N. Howard Street                   |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |                                    |  |   |   |  |
| Jacob T. Bromwell   |  | Lidia Beauchamp  |                                    |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)   |  | 16b. SOCIAL SECURITY NO.   |                                    | 17. INFORMANT ADDRESS  |   |   |  |
| No  |  | 214 40 4738  |                                    | Mr. Newton B. Brown, Balto., Md.   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ascvd</u><br><u>4292</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>several yrs.</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c)       |  |  |                                    |  |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).<br><u>decubitus ulcer of back</u> 3 weeks  |  |  |                                    |  |   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                    | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
|   |  |  |                                    |  |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)               |   |   |  |
|   |  |  |                                    |  |   |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                                    | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |   |  |
|   |  |  |                                    |  |   |   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>11-26-</u> 19 <u>54</u> to <u>Jan. 20</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>Jan 13</u> 19 <u>82</u> , and that in (my) (ours) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |                                    |  |   |   |  |
| 22b. SIGNATURE  |  | DEGREE   |                                    | 22c. DATE SIGNED   |   |   |  |
| <u>E. Ellsworth Cook</u>  |  |  |                                    | 1-22-82  |   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |                                    |  |   |   |  |
| Dr. E. Ellsworth Cook, M.D.   |  | 2431 Maryland Avenue, Balto., Md.  |                                    |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  | 23c. NAME OF CEMETERY OR CREMATORY |  | 23d. LOCATION CITY OR TOWN COUNTY STATE |   |  |
| Burial  |  | 1/25/82  | Loudon Park                        |  | Balto., Md.                             |   |  |
| 24. FUNERAL DIRECTOR NAME   |  | 25a. DATE REC'D. BY REGISTRAR  |                                    | 25b. REGISTRAR SIGNATURE   |   |   |  |
| Henry W. Jenkins & Sons Co.<br>4905 York Road Balto., Md. 21212   |  | JAN 25 1982  |                                    | <u>Thomas J. [Signature]</u>   |   |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 3 5 8

REG. NO.

|   |  |   |   |   |  |  |  |  |  |
|---|--|---|---|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>STAHLEY PASZKIEWICZ</b>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>JAN. 30 1982</b> |   |  | 2b. HOUR<br>M  |  |  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>   |   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>NOV. 13 1919</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS<br><b>62</b>                                   |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>                  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE CITY</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>CITY HOSPITAL</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>BALTIMORE</b>   |   | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13d. STREET ADDRESS<br><b>521 S. DECKER AVE.</b>                                   |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>PETER PASZKIEWICZ</b>   |  |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>JOSEPHINE KOKOSZKA</b>   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)<br><b>YES</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WW II</b>   |   | 17. INFORMANT ADDRESS<br><b>STAN. PASZKIEWICZ 2324 JOPPA RD.</b>  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiovascular Collapse</b><br>0389<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Sepsis</b><br>(c) <b>Undetermined etiology</b>                                    |  |   |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 minutes</b><br><b>2 weeks</b><br><b>7 days P.O.</b>                           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0   |  |   |   |   |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>1/28/82</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Sepsis</b>   |   |   |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/26</b> , 19 <b>81</b> , to <b>1/30</b> , 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>1/30</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Robert Udelman MD</b>  |  |   |   | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>1/30/82</b>   |  |  |  |
| 23a. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Robert Udelman MD</b>   |  |   |   | 23b. ADDRESS<br><b>128 S. Washington St. Baltimore MD.</b>  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>2/3/1982</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ST. STANISLAUS</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MD.</b>                    |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>RAYMOND L. KACOROWSKI</b>   |  |   |   | ADDRESS<br><b>2525 FLEET ST.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 2 1982</b>                                 |  | 25b. REGISTRAR'S SIGNATURE<br><b>James J. Nathan</b>   |  |

*[Faint, illegible handwriting throughout the page, likely bleed-through from the reverse side.]*



1905 State of New York

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH - 16 50M 1/81  
(VRA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 8 2 0 1 3 5 9   |  |  |  |
|---|--|--|--|---|--|--|--|
| FOR<br>1. STATE<br>REGISTRAR  |  |  |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>HELRNA IA PATTERSON</b>  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 12 82</b>   |  | 2b. HOUR<br><b>615 M</b>   |  |
| 3. SEX<br><b>F</b>  |  | 4. RACE<br><b>B</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>09 24 21</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>60</b> YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>US</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>CITY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNIV OF MD</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Health Assist.</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Health</b>   |  |
| 13a. STATE<br><b>MD</b>   |  |  |  | 13b. COUNTY<br><b>BALTO</b>   |  | 13c. CITY OR TOWN<br><b>BALTO</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>EUGENE WHEELER</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ALICE GLOVER</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>215-144-8734</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Mr. Oscar Patterson 2528 ELLAMONT</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic breast cancer</b><br><b>1749</b><br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF (c)          |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |   |  |  |  |
| <b>Heart failure</b>  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/8/81</b> , 19 <b>82</b> , to <b>1/12</b> , 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>1/11</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>W.B. Bell</b>  |  |  |  | 22c. DATE SIGNED<br><b>1/12/82</b>  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>W.B. Bell</b>  |  |
| 22e. ADDRESS<br><b>225 Greene St 21201</b>  |  |  |  | 22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>             |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>1-16-81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King Mem PK.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Randallstown Md.</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>AS. A. MORTON &amp; SONS 1701 LAURENS</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 18 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>James J. Nathan</b>   |  |

1537 BP



RECEIVED OCT 10 1964

UNITED STATES DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY OF AGRICULTURE  
WASHINGTON, D.C. 20250



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |   | REG. NO. 82 01360               |  |
|--|--|--|--|--|--|--|--|--|---|---------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Dominick</b>  |  |  | FIRST <b>Patti</b>   |  |  | MIDDLE   |  |  | LAST  |                                 |  |
| 2a. DATE OF DEATH  |  |  | MONTH <b>1</b>   |  |  | DAY <b>12</b>  |  |  | YEAR <b>82</b>  |                                 |  |
| 2b. HOUR <b>6:45</b>   |  |  | AM <b>AM</b>   |  |  |  |  |  |   |                                 |  |
| 3. SEX <b>male</b>   |  |  | 4. RACE <b>white</b>   |  |  | 5. DATE OF BIRTH   |  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.  |                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Italy</b>   |  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore</b> MD.   |                                 |  |
| 10. CITY OR TOWN OF DEATH <b>Randallstown, Md.</b>   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>old Court neg clw.</b> |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Shoe Repair</b>   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |                                 |  |
| 13a. STATE <b>Maryland</b>   |  |  | 13b. CITY OR TOWN <b>Baltimore Randallstown</b>  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  | 13e. STREET ADDRESS <b>5412 old Ct. Rd.</b>   |                                 |  |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |   |                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>   |  |  | 16b. SOCIAL SECURITY NO. <b>WW II 815-82-7514</b>  |  |  | 17. INFORMANT <b>Vincent Patti</b>   |  |  | ADDRESS <b>609 Mountain Rd. Fallston, Md.</b>   |                                 |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>4960</b> IMMEDIATE CAUSE (a) <b>End Stage COPO</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b> |  |  |  |  |  |  |  |  |   |                                 |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____  |  |  |  |  |  |  |  |  |   |                                 |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>1-11-82</b>  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <b>1-12-82</b>  |  |  |   |                                 |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |   |                                 |  |
| 22a. I certify that (1) this hospital attended the deceased from <b>1-11-82</b> to <b>1-12-82</b> , that (1) I saw the deceased alive on <b>1-11-82</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) I (we) (did not) view the body after death.   |  |  |  |  |  |  |  |  |   |                                 |  |
| 22b. SIGNATURE <b>M B Beckman</b> DEGREE _____   |  |  |  |  |  |  |  |  |   | 22c. DATE SIGNED <b>1-12-82</b> |  |
| 22d. PHYSICIAN'S NAME (PRINT OR TYPE) <b>M B Beckman</b>   |  |  |  |  |  | 22e. ADDRESS <b>5400 OLD COURT RD BALT MD</b>  |  |  |   |                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Entombment</b>  |  |  | 23b. DATE <b>Jan. 16, 1982</b>   |  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Maus.</b>  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>   |                                 |  |
| 24. FUNERAL DIRECTOR NAME <b>Leonard J. Ruck, Inc. Baltimore, Maryland</b> ADDRESS _____   |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>JAN 19 1982</b> 25b. REGISTRAR SIGNATURE <b>Charles J. Nathan</b>   |  |  |   |                                 |  |



SECRET

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

B 2 0 1 3 6 1

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |   |   |  |  |  |   |  |
|--|--|--|---|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Arthur Jerome Payne</b>  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>1 16 82</b>                    |   |  | 2b. HOUR<br><b>6:15<sup>AM</sup></b>   |  |   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Negro</b>  |   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>11 23 94</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>87</b> YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, Maryland MD.</b>                  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Agnes Hospital</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret. Minister</b>     |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Church</b>  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>13A/NO</b>   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>5901 Old Frederick Rd., Md. 21228</b>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>James Payne</b>  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Maggie Bonaparte</b> |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>218-36-7541</b>   |   | 17. INFORMANT ADDRESS<br><b>Baltimore Md. 21228 Rd.</b><br><b>Mrs. Odell W. Payne 5901 Old Frederick</b>  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>MYOCARDIAL INFARCTION</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
|  |  |  |   |   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |   |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/15</b> , 19 <b>82</b> , to <b>1/16</b> , 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>1/16</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                     |  |  |   |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Geetha Raja MD</b>  |  |  |   | DEGREE <b>RESIDENT</b><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  |  |  | 22c. DATE SIGNED<br><b>1/16/82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>GEETHA RAJA</b>  |  |  |   | 22e. ADDRESS<br><b>ST AGNES HOSPITAL, BALT, MD-21229</b>  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>1/21/82</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge Cemetery</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore County Md.</b>                       |  |   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Herbert E. Nutter Funeral Home</b>   |  | ADDRESS<br><b>Baltimore Maryland 21216</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 18 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>James J. Martin</b>   |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

100

1942. 2000. 2001. 2002. 2003. 2004. 2005. 2006. 2007. 2008. 2009. 2010. 2011. 2012. 2013. 2014. 2015. 2016. 2017. 2018. 2019. 2020. 2021. 2022. 2023. 2024. 2025. 2026. 2027. 2028. 2029. 2030. 2031. 2032. 2033. 2034. 2035. 2036. 2037. 2038. 2039. 2040. 2041. 2042. 2043. 2044. 2045. 2046. 2047. 2048. 2049. 2050. 2051. 2052. 2053. 2054. 2055. 2056. 2057. 2058. 2059. 2060. 2061. 2062. 2063. 2064. 2065. 2066. 2067. 2068. 2069. 2070. 2071. 2072. 2073. 2074. 2075. 2076. 2077. 2078. 2079. 2080. 2081. 2082. 2083. 2084. 2085. 2086. 2087. 2088. 2089. 2090. 2091. 2092. 2093. 2094. 2095. 2096. 2097. 2098. 2099. 2100. 2101. 2102. 2103. 2104. 2105. 2106. 2107. 2108. 2109. 2110. 2111. 2112. 2113. 2114. 2115. 2116. 2117. 2118. 2119. 2120. 2121. 2122. 2123. 2124. 2125. 2126. 2127. 2128. 2129. 2130. 2131. 2132. 2133. 2134. 2135. 2136. 2137. 2138. 2139. 2140. 2141. 2142. 2143. 2144. 2145. 2146. 2147. 2148. 2149. 2150. 2151. 2152. 2153. 2154. 2155. 2156. 2157. 2158. 2159. 2160. 2161. 2162. 2163. 2164. 2165. 2166. 2167. 2168. 2169. 2170. 2171. 2172. 2173. 2174. 2175. 2176. 2177. 2178. 2179. 2180. 2181. 2182. 2183. 2184. 2185. 2186. 2187. 2188. 2189. 2190. 2191. 2192. 2193. 2194. 2195. 2196. 2197. 2198. 2199. 2200. 2201. 2202. 2203. 2204. 2205. 2206. 2207. 2208. 2209. 2210. 2211. 2212. 2213. 2214. 2215. 2216. 2217. 2218. 2219. 2220. 2221. 2222. 2223. 2224. 2225. 2226. 2227. 2228. 2229. 2230. 2231. 2232. 2233. 2234. 2235. 2236. 2237. 2238. 2239. 2240. 2241. 2242. 2243. 2244. 2245. 2246. 2247. 2248. 2249. 2250. 2251. 2252. 2253. 2254. 2255. 2256. 2257. 2258. 2259. 2260. 2261. 2262. 2263. 2264. 2265. 2266. 2267. 2268. 2269. 2270. 2271. 2272. 2273. 2274. 2275. 2276. 2277. 2278. 2279. 2280. 2281. 2282. 2283. 2284. 2285. 2286. 2287. 2288. 2289. 2290. 2291. 2292. 2293. 2294. 2295. 2296. 2297. 2298. 2299. 2300. 2301. 2302. 2303. 2304. 2305. 2306. 2307. 2308. 2309. 2310. 2311. 2312. 2313. 2314. 2315. 2316. 2317. 2318. 2319. 2320. 2321. 2322. 2323. 2324. 2325. 2326. 2327. 2328. 2329. 2330. 2331. 2332. 2333. 2334. 2335. 2336. 2337. 2338. 2339. 2340. 2341. 2342. 2343. 2344. 2345. 2346. 2347. 2348. 2349. 2350. 2351. 2352. 2353. 2354. 2355. 2356. 2357. 2358. 2359. 2360. 2361. 2362. 2363. 2364. 2365. 2366. 2367. 2368. 2369. 2370. 2371. 2372. 2373. 2374. 2375. 2376. 2377. 2378. 2379. 2380. 2381. 2382. 2383. 2384. 2385. 2386. 2387. 2388. 2389. 2390. 2391. 2392. 2393. 2394. 2395. 2396. 2397. 2398. 2399. 2400. 2401. 2402. 2403. 2404. 2405. 2406. 2407. 2408. 2409. 2410. 2411. 2412. 2413. 2414. 2415. 2416. 2417. 2418. 2419. 2420. 2421. 2422. 2423. 2424. 2425. 2426. 2427. 2428. 2429. 2430. 2431. 2432. 2433. 2434. 2435. 2436. 2437. 2438. 2439. 2440. 2441. 2442. 2443. 2444. 2445. 2446. 2447. 2448. 2449. 2450. 2451. 2452. 2453. 2454. 2455. 2456. 2457. 2458. 2459. 2460. 2461. 2462. 2463. 2464. 2465. 2466. 2467. 2468. 2469. 2470. 2471. 2472. 2473. 2474. 2475. 2476. 2477. 2478. 2479. 2480. 2481. 2482. 2483. 2484. 2485. 2486. 2487. 2488. 2489. 2490. 2491. 2492. 2493. 2494. 2495. 2496. 2497. 2498. 2499. 2500. 2501. 2502. 2503. 2504. 2505. 2506. 2507. 2508. 2509. 2510. 2511. 2512. 2513. 2514. 2515. 2516. 2517. 2518. 2519. 2520. 2521. 2522. 2523. 2524. 2525. 2526. 2527. 2528. 2529. 2530. 2531. 2532. 2533. 2534. 2535. 2536. 2537. 2538. 2539. 2540. 2541. 2542. 2543. 2544. 2545. 2546. 2547. 2548. 2549. 2550. 2551. 2552. 2553. 2554. 2555. 2556. 2557. 2558. 2559. 2560. 2561. 2562. 2563. 2564. 2565. 2566. 2567. 2568. 2569. 2570. 2571. 2572. 2573. 2574. 2575. 2576. 2577. 2578. 2579. 2580. 2581. 2582. 2583. 2584. 2585. 2586. 2587. 2588. 2589. 2590. 2591. 2592. 2593. 2594. 2595. 2596. 2597. 2598. 2599. 2600. 2601. 2602. 2603. 2604. 2605. 2606. 2607. 2608. 2609. 2610. 2611. 2612. 2613. 2614. 2615. 2616. 2617. 2618. 2619. 2620. 2621. 2622. 2623. 2624. 2625. 2626. 2627. 2628. 2629. 2630. 2631. 2632. 2633. 2634. 2635. 2636. 2637. 2638. 2639. 2640. 2641. 2642. 2643. 2644. 2645. 2646. 2647. 2648. 2649. 2650. 2651. 2652. 2653. 2654. 2655. 2656. 2657. 2658. 2659. 2660. 2661. 2662. 2663. 2664. 2665. 2666. 2667. 2668. 2669. 2670. 2671. 2672. 2673. 2674. 2675. 2676. 2677. 2678. 2679. 2680. 26

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |  |  | 8 2 0 1 3 6 2  |     |   |           |  |  |
|---|--|--|--|--|--|---|--|--|--|--|-----|---|-----------|--|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO.   |  |  |  |   |  |  |  |  |     |   |           |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST  |  | MIDDLE   |  | LAST  |  | 2a. DATE OF DEATH  |  | MONTH  | DAY | YEAR  | 2b. HOUR  |  |  |
| CHARLES William PAYNE   |  |  |  |  |  |   |  | Jan 8 82   |  |  |     |   | 4:05 A.M. |  |  |
| 3 SEX   |  | 4 RACE   |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS  |     |   |           |  |  |
| Male  |  | Black  |  | 09 10 89   |  | 83 YRS  |  | MONTHS   |  | DAYS   |     | HOURS MIN.  |           |  |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |  |     |   |           |  |  |
| Maryland  |  | U.S.A.   |  |  |  | Baltimore city MD.  |  |  |  |  |     |   |           |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  |   |  |  |  |  |     | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |           | 12b. KIND OF BUSINESS OR INDUSTRY            |  |
| Baltimore   |  | Sinai Hospital of Baltimore  |  |  |  |   |  |  |  |  |     | CHAUFFER  |           | Cur Company                                  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?   |  | 13e. STREET ADDRESS  |     |   |           |  |  |
| Maryland  |  | Baltimore  |  | Baltimore  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | Baltimore, Maryland  |  | 5513 Haddon Ave 21207  |     |   |           |  |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |   |  |  |  |  |     |   |           |  |  |
| Benjamin Payne  |  | Lydia  |  |  |  |   |  |  |  |  |     |   |           |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | ADDRESS   |  |  |  |  |     |   |           |  |  |
| No  |  | 219-20-9422  |  | Baltimore Maryland   |  | Patricia Payne (wife)   |  | 5513 Haddon Ave 21207  |  |  |     |   |           |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  |  |  |  |  |  |   |  |  |  |  |     |   |           | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |  |  |   |  |  |  |  |     |   |           |  |  |
| IMMEDIATE CAUSE (a) cardiac arrest  |  |  |  |  |  |   |  |  |  |  |     |   |           |  |  |
| 1389 } DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |   |  |  |  |  |     |   |           |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |  |  |   |  |  |  |  |     |   |           |  |  |
| b) Comatose + Sepsis and sick sinus syndrome  |  |  |  |  |  |   |  |  |  |  |     |   |           |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |   |  |  |  |  |     |   |           |  |  |
| c) + prob. Encephalopathy   |  |  |  |  |  |   |  |  |  |  |     |   |           |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |  |  |  |  |  |   |  |  |  |  |     |   |           |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |     |   |           |  |  |
|   |  |  |  |  |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |     |   |           |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |  |     |   |           |  |  |
|   |  |  |  | HOUR A.M. MONTH DAY YEAR   |  |   |  |  |  |  |     |   |           |  |  |
|   |  |  |  | P.M. 19  |  |   |  |  |  |  |     |   |           |  |  |
| 21d. INJURY OCCURRED  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |   |  | 21f. LOCATION  |  |  |     |   |           |  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  |  |  |   |  | CITY OR TOWN COUNTY STATE  |  |  |     |   |           |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-21-1981 to 01-08-1982, that (I) (we) last saw the deceased alive on 1-08-1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |  |  |  |     |   |           |  |  |
| 22b. SIGNATURE  |  |  |  |  |  |   |  |  |  | DEGREE   |     | 22c. DATE SIGNED  |           |  |  |
| Truong Quang Le, MD   |  |  |  |  |  |   |  |  |  |  |     | 1/8/82  |           |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  |  |  |   |  |  |  | 22e. ADDRESS   |     |   |           |  |  |
| TRUONG QUANG LE   |  |  |  |  |  |   |  |  |  | Sinai Hospital of Baltimore                                    |     |   |           |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY                                  |  |  |  | 23d. LOCATION  |     |   |           |  |  |
| Burial  |  |  |  | 1/12/82  |  | Arbutus Mem. Park   |  |  |  | Baltimore County, Maryland                                     |     |   |           |  |  |
| 24. FUNERAL DIRECTOR NAME   |  |  |  |  |  |   |  |  |  | BALTIMORE MARYLAND 21216                                       |     | 25a. DATE REC'D. BY REGISTRAR                                 |           |  |  |
| HERBERT E. NUTTER FUNERAL HOME  |  |  |  |  |  |   |  |  |  | 3035 W. NORTH AVE  |     | JAN 11 1982   |           |  |  |
|   |  |  |  |  |  |   |  |  |  | 25b. REGISTRAR'S SIGNATURE                                     |     | Charles Jan Nathan  |           |  |  |

CHILLER

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|   |         |  |                    |  |                      |                                       |  |   |  |  |  |
|---|---------|--|--------------------|--|----------------------|---------------------------------------|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |         | 2. DATE KNOWN OF DEATH   |                    | 3. MONTH   |                      | 4. DAY                                |  | 5. YEAR   |  | 6. HOUR  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |         | 2. DATE KNOWN OF DEATH   |                    | 3. MONTH   |                      | 4. DAY                                |  | 5. YEAR   |  | 6. HOUR  |  |
| Howard J. Peacock SR  |         | 18 1982  |                    | 1  |                      | 18                                    |  | 1982  |  | M  |  |
| 7. SEX  | 8. RACE | 9. DATE OF BIRTH   | 10. AGE (IN YEARS) | 11. IF UNDER 1 YR.   | 12. IF UNDER 24 HRS. | 13. DATE PRONOUNCED DEAD              |  | 14. MONTH   |  | 15. DAY  |  |
| Male  | White   | 7/13/40  | 41 YRS             | MONTHS   | DAYS                 | 1                                     |  | 18  |  | 1982   |  |
| 16. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |         | 17. CITIZEN OF WHAT COUNTRY?   |                    | 18. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |                      | 19. BALTIMORE CITY OR COUNTY OF DEATH |  | 20. BALTIMORE CITY, MD.   |  | 21. HOUR   |  |
| MD.   |         | USA  |                    |  |                      | Baltimore City,                       |  |   |  | 5:02P M  |  |
| 22. CITY OR TOWN OF DEATH   |         | 23. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION   |                    | 24. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |                      | 25. KIND OF BUSINESS OR INDUSTRY      |  | 26. STEEL   |  | 27. HOUR   |  |
| Baltimore   |         | Baltimore City Hospital  |                    |  |                      |                                       |  |   |  | 5:02P M  |  |
| 28. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |         | 29. CITY OR TOWN   |                    | 30. INSIDE CITY LIMITS?  |                      | 31. STREET ADDRESS                    |  | 32. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 33. 2514 YORKWAY APT. B                          |  |
| MD  |         | BALTO  |                    | DUNDALK  |                      |                                       |  |   |  |  |  |
| 34. FATHER'S NAME   |         | 35. MOTHER'S MAIDEN NAME   |                    | 36. WAS DECEASED EVER IN U.S. ARMED FORCES?  |                      | 37. SOCIAL SECURITY NO.               |  | 38. INFORMANT   |  | 39. ADDRESS                                      |  |
| HARRY PEACOCK   |         | EVELYN RIETZ   |                    | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                      | 216 365740                            |  | IDA GURTNER   |  | 44 W. KINGSTON PK RD.                            |  |
| 40. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |         | 41. PART I DEATH WAS CAUSED BY:  |                    | 42. IMMEDIATE CAUSE (a) Pulmonary emboli   |                      | 43. DUE TO, OR AS A CONSEQUENCE OF    |  | 44. (b) Leg vein thrombosis   |  | 45. DUE TO, OR AS A CONSEQUENCE OF               |  |
| 4512  |         |  |                    |  |                      |                                       |  |   |  |  |  |
| 46. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). |         | 47. DATE OF OPERATION  |                    | 48. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |                      | 49. AUTOPSY?                          |  | 50. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 51. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
|   |         |  |                    |  |                      |                                       |  |   |  |  |  |
| 52. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH           |         | 53. TIME OF INJURY   |                    | 54. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |                      | 55. UNKNOWN                           |  | 56. UNKNOWN   |  | 57. UNKNOWN                                      |  |
| 58. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                   |         | 59. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |                    | 60. LOCATION   |                      | 61. CITY OR TOWN                      |  | 62. COUNTY  |  | 63. STATE  |  |
|   |         | unknown  |                    | unknown  |                      |                                       |  |   |  |  |  |
| 64. I certify that I took charge of the remains described above, held on death resulted from:   |         | 65. Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |                    | 66. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> |                      | 67. ACTUAL SIGNATURE                  |  | 68. TITLE (SPECIFY)   |  | 69. DATE SIGNED                                  |  |
|   |         |  |                    |  |                      | Thomas D. Smith                       |  | M.D. Deputy Chief   |  | 1/19/82  |  |
| 70. EXAMINER'S NAME (TYPE OR PRINT)   |         | 71. ADDRESS  |                    | 72. BALTIMORE CITY OR COUNTY   |                      | 73. STATE                             |  | 74. DATE REC'D. BY REGISTRAR  |  | 75. REGISTRAR'S SIGNATURE                        |  |
| Thomas D. Smith, M.D.   |         | 111 Penn St. Balto., Md.   |                    | BALTO.   |                      | MD                                    |  | JAN 21 1982   |  | James J. Smith                                   |  |
| 76. BURIAL, CREMATION, REMOVAL (SPECIFY)  |         | 77. DATE   |                    | 78. NAME OF CEMETERY OR CREMATORY  |                      | 79. LOCATION                          |  | 80. COUNTY  |  | 81. STATE  |  |
| BURIAL  |         | 1/24/82  |                    | OAK LAWN   |                      | BALTO.                                |  | MD  |  |  |  |
| 82. FUNERAL DIRECTOR  |         | 83. ADDRESS  |                    | 84. DATE REC'D. BY REGISTRAR   |                      | 85. REGISTRAR'S SIGNATURE             |  | 86. DATE REC'D. BY REGISTRAR  |  | 87. REGISTRAR'S SIGNATURE                        |  |
| J.G. CONNELLY   |         | 300 MACE   |                    | JAN 21 1982  |                      | James J. Smith                        |  |   |  |  |  |

MEDICAL CERTIFICATION

0000

1947-1948



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 3 6 4

|   |  |  |   |  |  |
|---|--|--|---|--|--|
| 1. FOR STATE REGISTRAR  |  | 2a. DATE OF DEATH  |   | 2b. HOUR   |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | 2a. DATE OF DEATH  |   | 2b. HOUR   |  |
| FIRST MIDDLE LAST   |  | MONTH DAY YEAR   |   | HRS MIN.   |  |
| William P. Pearce, Sr.  |  | January 13, 1982   |   | 4:08p  |  |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY)                               | IF UNDER 1 YEAR  |  |
| Male  | White  | February 11, 1909  | 72  | MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                          |  |  |
| Maryland  | U.S.A.   |  | Baltimore City MD.  |  |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY            |
| Baltimore   | Union Memorial Hospital  |  | Housepainter  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13b. INSIDE CITY LIMITS?   |   | 13c. STREET ADDRESS  |  |
| 13a. STATE  |  | 13b. CITY OR TOWN  |   | 13c. STREET ADDRESS  |  |
| Maryland  |  | Baltimore  |   | 840 Powers Street  |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |   |  |  |
| FIRST MIDDLE LAST   |  | FIRST MIDDLE LAST  |   |  |  |
| Parker Pearce   |  | Katie Kramer   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT ADDRESS  |  |
| No  |  | 217 18 6158  |   | Shirley Pearce Same  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>Acute myocardial Infarction - ventricular fibrillation</u>   |  |  |   |  | 1 hr   |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary artery disease 2° ASCVD</u>  |  |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Congestive Heart failure, Atrial fibrillation (episodic), Angina Pectoris</u>   |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?  |  |
|   |  |  |   | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
|   |  | P.M. 19  |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |
|   |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>JAN 3</u> , 19 <u>81</u> , to <u>JAN 13</u> , 19 <u>82</u> , that (I) <u>met</u> <del>met</del> <u>last</u> saw the deceased alive on <u>DEC 11</u> , 19 <u>81</u> , and that in (my) <u>last</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>we</u> <del>we</del> <u>did not</u> view the body after death. |  |  |   |  |  |
| 22b. SIGNATURE  |  | DEGREE   |   | 22c. DATE SIGNED   |  |
| <u>Charles O'Donovan III</u>  |  | MD   |   | JAN 15, 1982   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |   |  |  |
| Dr. Charles O' Donovan III  |  | 9 E. Chase Street  |   | Baltimore, Md.   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY   |  |
| Burial  |  | 16 Jan 82  |   | Mt. Zion Cemetery  |  |
| 23d. LOCATION CITY OR TOWN COUNTY STATE   |  | 23e. DATE REC'D. BY REGISTRAR  |   |  |  |
| Freelands, Balto. Co., Md.  |  | JAN 18 1982  |   |  |  |
| 24. FUNERAL DIRECTOR NAME   |  | 24b. ADDRESS   |   | 25. REGISTRAR'S SIGNATURE  |  |
| Burgee Funeral Home, 3631 Falls Rd. 21211   |  |  |   | <u>Frances Jean Northern</u>   |  |

4:30

January 13, 1952

William E. Brown, Jr.

February 11, 1952

Baltimore City

Union Memorial Hospital

340 Forest Street

Baltimore

Chilley House

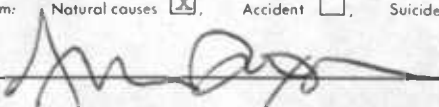
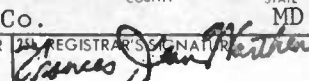


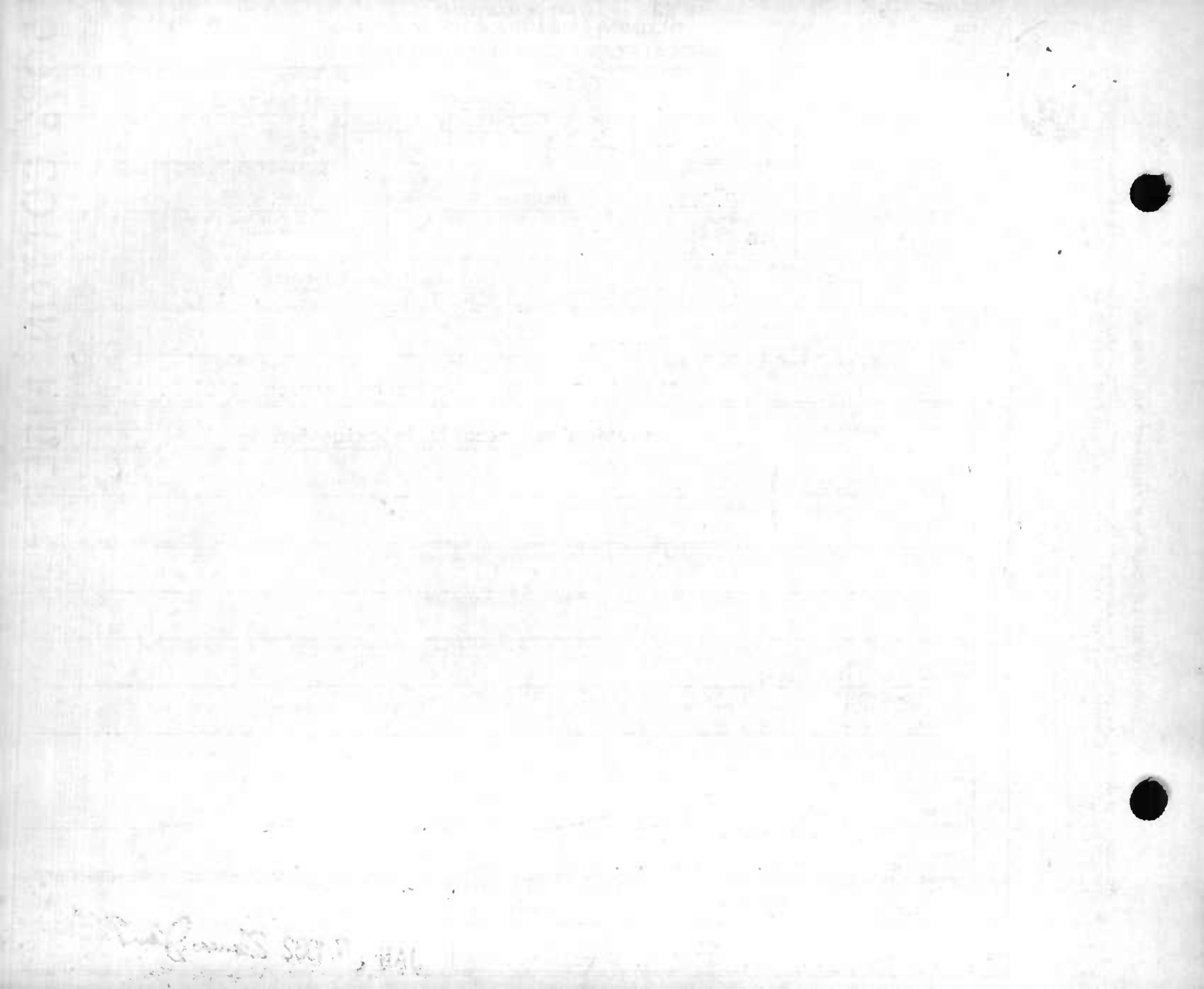
Mr. Charles J. Donovan III, 9 E. Green Street, Baltimore, Md.

15 Jan 52, 10:10 AM

18 Jan 52, 10:10 AM

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                         |  |  |   |                                |   |  |   |                     | REG. NO. 7 2 0 1 3 6 5 |  |
|--|-------------------------|--|--|---|--------------------------------|---|--|---|---------------------|------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>WILLIE A. PEARSON</b>   |                         |  |  |   |                                |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> 1 1 19 82 |   | 2b. HOUR<br>M 12:23 |                        |  |
| 3. SEX<br><b>male</b>  | 4. RACE<br><b>negro</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9 25 54</b>   | 6. AGE (IN YEARS<br>LAST BIRTHDAY)<br><b>27</b> YRS. | IF UNDER 1 YR.<br>MONTHS DAYS   | IF UNDER 24 HRS.<br>HOURS MIN. | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>1 2 19 82</b>  |  | 2d. HOUR<br>a M   |                     |                        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  |   |                     |                        |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>923 N. Castle St.</b> |  |   |                                | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |                     |                        |  |
| 13a. STATE<br><b>MD</b>  |                         | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |                                | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                     |  | 13e. STREET ADDRESS<br><b>923 N. Castle St.</b>                                     |                     |                        |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Anderson Pearson</b>  |                         |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Minnie Davis</b>  |                                |   |  |   |                     |                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |                         | 16b. SOCIAL SECURITY NO.<br><b>214-62-9701</b>   |  | 17. INFORMANT ADDRESS<br><b>Anderson Pearson 1645 E. 25th St.</b>   |                                |   |  |   |                     |                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br><b>3049</b> IMMEDIATE CAUSE (a) <b>Narcotism and alcohol intoxication</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |                         |  |  |   |                                |   |  |   |                     |                        |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |                         |  |  |   |                                |   |  |   |                     |                        |  |
| 19a. DATE OF OPERATION   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |                                |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                     |                        |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |                                |   |  |   |                     |                        |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                |   |  |   |                     |                        |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .<br>TITLE (SPECIFY)<br>M.D. <b>Assistant</b> MEDICAL EXAMINER<br>DATE SIGNED <b>1-2-82</b> |                         |  |  |   |                                |   |  |   |                     |                        |  |
| ACTUAL SIGNATURE<br>  |                         | EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b> ADDRESS <b>111 Penn St.</b>  |  |   |                                |   |  |   |                     |                        |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |                         | 23b. DATE<br><b>1/9/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King Memorial Park</b>   |                                | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Co. MD</b>  |  |   |                     |                        |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H, Inc. 1101 E. North Ave.</b>   |                         |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 7 1982</b>  |                                | 25b. REGISTRAR'S SIGNATURE<br> |  |   |                     |                        |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 8 2 0 1 3 6 6   |  |
|--|--|--|--|---|--|
| 1- FOR STATE REGISTRAR   |  |  |  | CERTIFICATE OF DEATH  |  |
| I. DECEASED NAME<br>(TYPE OR PRINT)  |  |  |  | REG. NO.  |  |
| BEATRICE<br>BEATRICE   |  | MIDDLE   |  | PEASE<br>PEASE  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>white   |  | 5. DATE OF BIRTH<br>2-14-95<br>MONTH DAY YEAR<br>2 14 95                                    |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Penna.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>86<br>YRS  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF CONTACTED, GIVE STREET ADDRESS)<br>SOUTH BALTIMORE GENERAL HOSP<br>S.B.G.H. |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                  |  |
| 13a. STATE<br>MD   |  | 13b. COUNTY<br>BALTIMORE   |  | 13c. CITY OR TOWN<br>BALTIMORE  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>George Swope   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Sarah Whitelock   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Practical Nurse Private |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>no   |  | 16b. SOCIAL SECURITY NO.<br>213-28-4996  |  | 17. INFORMANT<br>ADDRESS<br>Bethany Beach<br>Dela.  |  |
| 18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Heart failure</u><br>5850<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <u>Septic S/P dian intra abd. abscess</u><br>(c) <u>ATrial F.C., severe COPD</u><br><u>chronic renal failure</u> |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>4 days                                      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BY NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>chronic renal failure</u>   |  |  |  |   |  |
| 19a. DATE OF OPERATION<br>1/10/82  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Aortic Stenosis<br>replaced S.B.G.H.   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>        |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)              |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/28/81</u> 19 <u>81</u> , to <u>1/15/82</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>1/15/82</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                 |  |  |  |   |  |
| 22b. SIGNATURE<br><u>Boudrop</u>   |  |  |  | 22c. DATE SIGNED<br>1/15/82   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>BADRO   |  |  |  | 22e. ADDRESS<br>S.B.G.H.  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>1/19/82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Lakeview Mem. Pk.                                     |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md.  |  | 24. FUNERAL DIRECTOR<br>Schimmek Funeral Home, Inc.<br>3331 Brehms Lane, Balto. Md. 21213  |  |   |  |
| 25a. DATE REC'D. BY REGISTRAR<br>JAN 19 1982   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Francis J. Thornton</u>                                    |  |

Handwritten: 1805 1 14

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |   |  | 8 2 0 1 3 6 7   |  |       |  |      |  |          |  |
|--|--|---|--|---|--|--|--|---|--|---|--|-------|--|------|--|----------|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 2a. DATE OF DEATH   |  |   |  |  |  |   |  | MONTH   |  | DAY   |  | YEAR |  | 2b. HOUR |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST   |  | MIDDLE  |  | LAST   |  | 2a. DATE OF DEATH   |  | MONTH   |  | DAY   |  | YEAR |  | 2b. HOUR |  |
| John   |  | Roland  |  | Pensmith Sr.  |  | January 20 1982  |  | 12:30   |  | M   |  |       |  |      |  |          |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR   |  | IF UNDER 24 HRS   |  |       |  |      |  |          |  |
| Male   |  | Caucasian   |  | Oct 31 1910   |  | 71 YRS   |  | MONTHS  |  | DAYS  |  | HOURS |  | MIN. |  |          |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |   |  |   |  |       |  |      |  |          |  |
| Md.  |  | U.S.A.  |  |   |  | Baltimore City   |  | MD.   |  |   |  |       |  |      |  |          |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY   |  |   |  |   |  |       |  |      |  |          |  |
| Baltimore  |  | 3909 Shannon Drive  |  | Carpenter   |  | Local 101  |  |   |  |   |  |       |  |      |  |          |  |
| 13a. STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?   |  | 13e. STREET ADDRESS   |  |   |  |       |  |      |  |          |  |
| Md.  |  |   |  | Baltimore   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 3909 Shannon Drive  |  |   |  |       |  |      |  |          |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME  |  |   |  |  |  |   |  |   |  |       |  |      |  |          |  |
| John   |  | Pensmith  |  | Mary  |  | Croghan  |  |   |  |   |  |       |  |      |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   |  | 17. INFORMANT   |  | ADDRESS  |  |   |  |   |  |       |  |      |  |          |  |
| no   |  | 215-07-5982   |  | Viola Pensmith (wife)   |  | same address   |  |   |  |   |  |       |  |      |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>A.S.C.V.D. with aortic valve prosthesis r</u><br><u>4292</u> DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>A.S.C.V.D.</u> C.H.F.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>and C.H.F.</u><br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause last. |  |   |  |   |  |  |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>6 years</u> |  |       |  |      |  |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>C.O.P.D.</u>   |  |   |  |   |  |  |  |   |  |   |  |       |  |      |  |          |  |
| 19a. DATE OF OPERATION<br><u>1975</u>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>To Replace aortic valve.</u>                       |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |       |  |      |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B. PART 1 OR PART 2)  |  |  |  |   |  |   |  |       |  |      |  |          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |   |  |       |  |      |  |          |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>1-1975</u> 19, to date of death 19, that (I) (we) lost<br>saw the deceased alive on <u>Nov. 12, 1981</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did not) view the body after death.  |  |   |  |   |  |  |  |   |  |   |  |       |  |      |  |          |  |
| 22b. SIGNATURE<br><u>Farid S. Abid, M.D.</u>   |  |   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><u>1-21-82</u>  |  |   |  |       |  |      |  |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Dr. Farid Abid F.S. ABID</u>   |  |   |  |   |  | 22e. ADDRESS<br><u>5002 Frankford Ave.</u>   |  |   |  |   |  |       |  |      |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |   |  |   |  |       |  |      |  |          |  |
| Cremation  |  | 1/21/82   |  | Greenmount Crematory  |  | Balto.   |  | Md.   |  |   |  |       |  |      |  |          |  |
| 24. FUNERAL DIRECTOR<br><u>Schimunek Funeral Home, Inc.</u><br><u>3331 Brehms Lane, Balto. Md. 21213</u>   |  |   |  |   |  | 25a. DATE RECD BY REGISTRAR (BY REGISTRAR'S SIGNATURE)<br><u>JAN 22 1982</u>   |  |   |  |   |  |       |  |      |  |          |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH-16 50M 1/81  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 8 2 0 1 3 6 8   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>IDA M. PERRIER</b>   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR HOUR<br><b>1 28 82 5:25a</b>   |  |  |  |
| 3. SEX <b>Female</b>  |  | 4. RACE <b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 10 07</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>BALTO.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. CITY</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO. MD.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MERCY HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>XXXXXXXXXXXX</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Apt. House Manager</b>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD.</b> 13b. COUNTY <b>BALTO. XXXX</b> 13c. CITY OR TOWN <b>BALTO.</b>  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>7013 LACHLAN CIRCE</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOHN</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ANNIE EBLER</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>  |  |  |  |
| 16b. SOCIAL SECURITY NO.<br><b>212-09-9485</b>  |  | 17. INFORMANT<br><b>Arthur J. Perrier</b>  |  |   |  | ADDRESS<br><b>14003 Foxland Road</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b><br><b>1830</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>OVARIAN CARCINOMA</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(c) <b>METASTATIC SPREAD</b> |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>CONTRIBUTING TO DEATH</b>  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/28</b> , 19 <b>81</b> , to <b>1/28</b> , 19 <b>82</b> , that (I) (we) lost<br>saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                          |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Mary Carroll</b>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>1/28/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MARY CARROLL</b>  |  |  |  | 22e. ADDRESS<br><b>MERCY HOSPITAL, BALTO. MD.</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>1982 Jan. 30, 1982</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley Cem.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Cockeysville, Baltimore, Md.</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Ruck Towson Funeral Home, Inc. Towson, Md. 21204</b>   |  |  |  | 25. DATE OF DEATH<br><b>JAN 29 1982</b>   |  |  |  |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 027-3300 9  
REG. NO.

|  |   |   |   |  |  |
|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Grace A. Peterson (Lambert)</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>01 07 82</b>  |  | 2b. HOUR<br><b>1:40 PM</b>   |
| 3. SEX<br><b>F</b>   | 4. RACE<br><b>B</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12-3-54</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>27</b> YRS.                                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>md.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>City</b> MD.  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Bon Secours Hosp.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Unemployed</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>md.</b>   | 13b. COUNTY<br><b>Balto.</b>  | 13c. CITY OR TOWN<br><b>Balto.</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   | 13e. STREET ADDRESS<br><b>1819 Annapolis Ave.</b>                                    |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Willie G. Peterson</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Dorothy Malone</b>  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>168-46-8444</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Dorothy A. Lambert 649 N. 33rd. St.</b>               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Intracranial Hemorrhage with irreversible brain damage</b><br>4329<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <b>Hyperfusion</b><br>(c) <b>Bilateral pneumonia</b> |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:   |   |   |   |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>1:40 PM 1/7 1982</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/18/81</b> to <b>1/7/82</b> , that (I) (we) lost<br>saw the deceased alive on <b>1/7/82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                  |   |   |   |  |  |
| 22b. SIGNATURE<br><b>Wendy A. Bode</b>   |   | DEGREE<br><b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>1/7/82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Wendy A. Bode, MD</b>  |   | 22e. ADDRESS<br><b>5411 Old Frederick Rd Balto. Md 21229</b>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   | 23b. DATE<br><b>1/11/82</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem. Pk.</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY MD<br><b>Baltimore Co.</b>                      |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H</b>  |   | ADDRESS<br><b>1101 E. North Ave.</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 8 1982</b>                                   |  |
|  |   | 25b. REGISTRAR'S SIGNATURE<br><b>James J. [Signature]</b>   |   |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 8 2-01370   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>BETTY EILEEN PEZZICA</b>  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>January 14, 1982</b>   |  | 2b. HOUR<br><b>10 30 A M</b>   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>April 5, 1919</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS<br><b>62</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD.</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Union Memorial Hospital</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN<br><b>Maryland Baltimore</b>   |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>503 E. 30th Street</b>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Harvey Erb</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Ethel ?</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>--</b>  |  | 17. INFORMANT ADDRESS<br><b>Donald E. Pezzica, Balto., Md.</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4360</b> IMMEDIATE CAUSE (a) <b>CVA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br><b>19 pertension</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br><b>Several mos.</b> |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Immediate</b>   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9-7-</b> 19 <b>61</b> , to <b>1-14</b> 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>1-12</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                 |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>E. Ellsworth Cook</b>   |  |  |  | DEGREE<br><b>M.D.</b>   |  | 22c. DATE SIGNED<br><b>1-15-82</b>   |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. E. Ellsworth Cook, M.D.</b>  |  |  |  | 22f. ADDRESS<br><b>2431 Maryland Ave., Balto., Md.</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>1/16/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lake View Memorial</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Balto., Md.</b>  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Henry W. Jenkins &amp; Sons Co.</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 18 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |
| 4905 York Road Balto., Md. 21212   |  |  |  |   |  |  |  |

U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C. 20535

January 1, 1964

MEMORANDUM FOR THE DIRECTOR

Attorney General

U.S.A.

Division

Union Memorial Hospital

Division

600 E. 10th Street

St. Paul, Minn.

Division

St. Paul

St. Paul

Division

Conrad E. Phipps, M.D.

To

1/1/64

1/1/64



Mr. E. Ellsworth Cook, M.D., 1401 Maryland Ave., S.W., Wash., D.C.

1/1/64 - Lines View Memorial, S.W., Wash., D.C.

James W. Larkin & Son, Inc.

425 York Ave., N.Y.C. 10017



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 8 2 0 1 3 7 1  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  | CERTIFICATE OF DEATH   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  |  |  |
| WILLIAM T. PFEIFFER  |  |   |  | Jan. 23 82 12 50 PM  |  |  |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS (LAST BIRTHDAY))                              |  |
| Male   |  | Caucasian   |  | 05 26 11   |  | 70 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |  |
| England  |  | USA   |  |  |  | Baltimore City MD  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| Baltimore  |  | LUTHERAN HOSPITAL   |  | Personnel Dir.   |  | A & P Food   |  |
| 13a. STATE   |  |   |  | 13b. CITY OR TOWN  |  |  |  |
| Virginia   |  |   |  | Oakton   |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |  |  |
| August W. Pfeiffer   |  |   |  | Johanna Richter  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES]  |  |   |  | 16b. SOCIAL SECURITY NO.   |  |  |  |
| No   |  |   |  | 577-09-4877  |  |  |  |
| 17. INFORMANT ADDRESS  |  |   |  | 17. INFORMANT ADDRESS  |  |  |  |
| A Lina P. DeGonzalez   |  |   |  | Same as 13   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |   |  |  |  |  |  |
| PART I. DEATH WAS CAUSED BY:   |  |   |  |  |  |  |  |
| IMMEDIATE CAUSE (a) Cardio respiratory arrest  |  |   |  |  |  |  |  |
| 4850   |  |   |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) Broncho pneumonia   |  |   |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |  |  |  |  |  |
| ALZHEIMER DISEASE  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
|  |  | P.M. 19   |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                 |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |
|  |  |   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 01-17-82, 19, to 01-23, 1982, that (I) (we) last saw the deceased alive on Jan 23, 12 50 PM 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |  |  |
| 22b. SIGNATURE   |  | DEGREE  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |  | 22c. DATE SIGNED   |  |
| [Signature]  |  | MD  |  |  |  | 1-23-82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   |  | 22e. ADDRESS   |  |  |  |
| Claudio F. Lenata  |  |   |  | Lutheran Hospital, 730 Ashburton St Baltimore, MD  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                        |  |
| Burial   |  | January 30 1982   |  | Gate of Heaven Cem.  |  | Silver Spring, Maryland  |  |
| 24. FUNERAL DIRECTOR NAME  |  |   |  | 25a. DATE REC'D. BY REGISTRAR  |  |  |  |
| Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland  |  |   |  | FEB 1 1982   |  |  |  |
|  |  |   |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |
|  |  |   |  | [Signature]  |  |  |  |

MEDICAL CERTIFICATION

STANDARD FORM NO. 64  
MAY 1962 EDITION  
GSA FPMR (41 CFR) 101-11.6



NOV 10 1962

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

BP

Items 21a. -21f. & 22a. DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 0 1 3 7 2  
1. FOR STATE REGISTRAR AL

CERTIFICATE OF DEATH

REG. NO.

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Elivor PRESTON Phillips</b>   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>01 08 82</b>   |   | 2b. HOUR<br><b>8:42 AM</b>   |  |
| 3. SEX<br><b>7</b>   | 4. RACE<br><b>Caucasian</b>  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>04 10 04</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN<br><b>77</b> YRS.                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>      |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>South Baltimore General</b> |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired sales clerk</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY                  |
| 13a. STATE<br><b>md.</b>   |  | 13b. COUNTY<br><b>Anne Arundel</b>  | 13c. CITY OR TOWN<br><b>Annapolis</b>   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>150 E. Bayview Drive</b> |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Carroll L. Brewington</b>  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Bessie Preston</b>   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>214-10-9433</b>  |   | 17. INFORMANT (son) ADDRESS<br><b>Mr. Norman A. Phillips same as 13</b>                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:<br><b>9889</b> IMMEDIATE CAUSE (a) <b>Cardio Pulmonary Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Pulmonary Embolism</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Fracture of Right Hip.</b>  |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH       |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |   |  |  |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br><b>Baltimore City</b>                      |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 8</b> , 19 <b>82</b> , to <b>Jan 8</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>Dec 30</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |  |  |
| 22b. SIGNATURE<br><b>Sandra L. Howard M.D.</b>   |  | DEGREE<br><b>Undetermined</b>   |   | 22c. DATE SIGNED<br><b>Jan. 8, 1982</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Sandra L. Howard M.D.</b>  |  | 22e. ADDRESS<br><b>3001 S. Hanover St Balt. MD.</b>   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>1/11/82</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parsons Cemetery Salisbury, Wic., Maryland</b>      |  |
| 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Salisbury, Wic., Maryland</b>  |  | 24. FUNERAL DIRECTOR<br><b>HOLLOWAY FUNERAL HOME, Salisbury, Md.</b>  |   |  |  |
| 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 12 1982</b>  |  | 25b. REGISTRAR SIGNATURE<br><b>James J. [Signature]</b>   |   |  |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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BP 6  
DHMH-16 25M  
(VRA 15, 4) 1/79

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 3 7 3

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|  |  |  |  |   |   |  |   |   |  |                            |                                       |  |
|--|--|--|--|---|---|--|---|---|--|----------------------------|---------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Lorraine PHILLIPS   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>January 7, 1982                 |   |   | 2b. HOUR<br>6:30a M  |   |   |  |                            |                                       |  |
| 3. SEX<br>F  |  | 4. RACE<br>BIK   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3-2-46  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>35 YRS.   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |                            |                                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                           |   |   |  |                            |                                       |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Maryland General Hospital |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |                            |                                       |  |
| 13a. STATE<br>Md   |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN<br>Baltimore                      |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br>405 Pitman Pl         |                            |                                       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Albert Parkin  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Hattie Joyce          |   |   |  |   |   |  |                            |                                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |  | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br>218-44-4931  |   | 17. INFORMANT<br>Hattie Moore 1127 Orleans St       |  |   |   |  |                            |                                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Hepatic Metamorphosis<br>5713<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Upper Gastrointestinal hemorrhage, due to Pancreatitis and<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) Clinical history of Alcoholism<br>Esophagitis. |  |  |  |   |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                            |                                       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>Radiation change of the Cervix, with history of Carcinoma.  |  |  |  |   |   |  |   |   |  |                            |                                       |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                 |  |                            |                                       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |   |   |  |                            |                                       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |   |  |                            |                                       |  |
| 22a. I certify that (x) (this hospital) attended the deceased from January 6, 1982, to January 7, 1982, that (x) (we) last saw the deceased alive on January 7, 1982, and that in (y) (our) opinion death occurred on the date and hour and from the causes stated above. (x) (we) (did) (not) view the body after death.  |  |  |  |   |   |  |   |   |  |                            |                                       |  |
| 22b. SIGNATURE<br>Harry M. Harris MD   |  |  |  |   |   | DEGREE<br>MD   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>1/7/82 |                                       |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Harry Harris, M.D.  |  |  |  |   |   | 22e. ADDRESS<br>c/o Maryland General Hospital  |   |   |  |                            |                                       |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |  | 23b. DATE<br>1/14/82   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Redeemer |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md  |  |                            |                                       |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Jernon R. Bailey   |  |  |  |   |   | ADDRESS<br>1348 N. Calhoun St  |   | 25a. DATE REC'D. BY REGISTRAR<br>JAN 18 1982  |  |                            | 25b. REGISTRAR'S SIGNATURE<br>Frances |  |



January 1, 1952

January 1, 1952

January 1, 1952

January 1, 1952

January 1, 1952

January 1, 1952

January 1, 1952

January 1, 1952

January 1, 1952

January 1, 1952

January 1, 1952

January 1, 1952

JAN 18 1952

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO. 82 01374  |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR 1 19 82   |  |   |  |
| 1. DECEASED NAME FIRST MIDDLE LAST PROCTOR PICKELSIMER   |  |  |  | 2b. HOUR 4:15 AM   |  |   |  |
| 3. SEX MALE  |  | 4. RACE CAUCASIAN  |  | 5. DATE OF BIRTH MONTH DAY YEAR 1 12 09  |  | 6. AGE (IN YEARS (LAST BIRTHDAY)) 73 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) KENTUCKY   |  | 7b. CITIZEN OF WHAT COUNTRY? USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD.   |  |
| 10. CITY OR TOWN OF DEATH BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY OF MARYLAND Hospital |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED  |  | 12b. KIND OF BUSINESS OR INDUSTRY Md. Drydock   |  |
| 13a. STATE MARYLAND  |  |  |  | 13b. COUNTY CITY   |  | 13c. CITY OR TOWN BALTIMORE   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST W. PICKELSIMER   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST I. D. HOWARD  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No   |  |  |  | 16b. SOCIAL SECURITY NO. 289-09-4789   |  | 17. INFORMANT CHART (hospital)  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GASTROINTESTINAL hemorrhage 2060 DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE Monocytic leukemia (thrombocytopenia) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10.   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 3, 19 82, to Jan 19, 19 82, that (I) (we) lost saw the deceased alive on Jan 19, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.          |  |  |  |  |  |   |  |
| 22b. SIGNATURE JUDAH MINKOW  |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |  | 22c. DATE SIGNED 1/19/82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JUDAH MINKOW   |  | 22e. ADDRESS 22 S. GREENE ST. BALTIMORE, MD 21201  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial   |  | 23b. DATE 22 Jan. 82   |  | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, AA, Maryland   |  |
| 24. FUNERAL DIRECTOR James S. Kirkley, Glen Burnie, Md.  |  |  |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR Francis J. Nathan   |  |   |  |



SECRET

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |  |  | REG. NO. 8 2 0 1 3 7 5                                       |  |
|---|--|---|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>SALVATORE P. PITARRA JR.</b>   |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>1 15 1982</b>  |  | 2b. HOUR <b>9:45 P.M.</b>  |  |  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>2 5 1910</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |  |  |
| 7a. BIRTHPLACE<br>STATE OR FOREIGN COUNTRY <b>MD</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>                               |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3019 GLEN AVE 21215</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RESTAURANT OWNER</b>     |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>SELF (RETIRED)</b>   |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD</b>  |  | 13b. COUNTY <b>BALTO.</b>   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>3019 GLEN AVE, 21215</b>   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>SALVATORE P. PITARRA SR.</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>CONCETTI MUFFOLETTO</b>  |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>219-12-8035</b>  |  | 17. INFORMANT ADDRESS<br><b>MARY E. PITARRA (SAME)</b>  |  |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of Esophagus</b><br><b>1509</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) }<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) } |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 yr.</b> |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>1509</b>  |  |   |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>Sept 1981</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Carcinoma of Esophagus</b>   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Sept 1981</b> to <b>present</b> 19 <b>81</b> , that (I) (we) lost saw the deceased alive on <b>December 19 81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) did not view the body after death.                    |  |   |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><i>[Signature]</i>  |  |   |  | DEGREE  |  |   |  | 22c. DATE SIGNED<br><b>1/15/82</b>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Schulz, M.J.</b>  |  |   |  | 22e. ADDRESS<br><b>2435 W. Belvedere Ave 21215</b>  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>BURIAL</b>  |  | 23b. DATE<br><b>1/18/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>PRUDRIDGE CEMETERY</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>PIKESVILLE BALTO. MD</b>                       |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>NEWELL F.H. P. KESVILLE, MD.</b> ADDRESS  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 18 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |  |  |

1911-1912

1912-1913

1913-1914

1914-1915

1915-1916

1916-1917

1917-1918

1918-1919

1919-1920

1920-1921

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |   |   |   |   |   |  |  | 8 2 0 1 3 7 6                                  |
|---|--|--|---|---|---|---|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |   |   |   |   |   |  |  | REG. NO.                                       |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ENGENE H. PITTMAN JR</b>   |  |  |   |   | 2a. DATE OF DEATH<br>MONTH <b>1</b> DAY <b>16</b> YEAR <b>82</b>                          |   | 2b. HOUR<br><b>9:35 PM</b>  |  |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br>MONTH <b>8</b> DAY <b>6</b> YEAR <b>39</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>42</b> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>   |  | IF UNDER 24 HRS.<br>HOURS <b></b> MIN. <b></b> |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                       |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Mercy Hospital</b> |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ass't V.P./ Mercantile Trust</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE <b>Maryland</b> COUNTY <b>A.A. Co.</b>  |  |  |   |   | 13b. CITY OR TOWN<br><b>Baltimore</b>   |   | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                 |  | 13d. STREET ADDRESS<br><b>325 Walton Avenue,</b>           |  |
| 14. FATHER'S NAME<br>FIRST <b>Eugene H.</b> MIDDLE <b>Pittman</b> LAST <b>Sr.</b>   |  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Margaret</b> MIDDLE <b>Pauline</b> LAST <b>Berry</b> |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>Yes</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>n/a</b>                                      |   | 17. INFORMANT<br><b>Barbara A. Pittman</b>  |   | ADDRESS<br><b>Same as #13</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY,<br>IMMEDIATE CAUSE (a) <b>Acute Hemolytic Crisis</b><br><b>5830</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Autoimmune Hemolytic Anemia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |   |   |   |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1<br><b>Myocardial Infarction / Renal Failure</b>   |  |  |   |   |   |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                            |   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                    |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>5:10 P.M. 1 19 82</b> |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)                          |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)      |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/16/82</b> to <b>1/16/82</b> , that (I) (we) lost saw the deceased alive on above, (I) (we) (did) (did not) view the body after death.   |  |  |   |   |   |   |   |  |  |  |
| 22b. SIGNATURE<br><b>K.C. Kunn</b>  |  |  |   |   | DEGREE<br><b>MD</b>   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1/16/82</b>                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>K.C. Kunn</b>   |  |  |   |   | 22e. ADDRESS<br><b>Mercy Hosp.</b>  |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>  |  |  | 23b. DATE<br><b>1/20/1982</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Mem. Ph.</b>                          |   | 23d. LOCATION<br>CITY OR TOWN <b>Glen Burnie, A. A. Co., Md.</b> COUNTY STATE   |  |  |  |
| 24. FUNERAL DIRECTOR<br>(NAME)<br><b>McQuilly Funeral Home</b>  |  |  |   |   | BALTO., MD., 21225<br><b>237 E. Patapsco Ave.,</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 19 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Thomas J. [Signature]</b> |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by one of the following:

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 8 2 0 1 3 7 7  |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |   |  | REG. NO.   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>ANNA PLAHN</b>  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>JANUARY 11, 1982</b>   |  | 2b. HOUR <b>12:15AM</b>   |  |
| 3. SEX <b>Female</b>  |  | 4. RACE <b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>7 27 13</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pa.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH <b>Balto.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>JOHNS HOPKINS HOSPITAL</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE <b>Md.</b>   |  |   |  | 13b. COUNTY <b>Baltimore</b>   |  | 13c. CITY OR TOWN <b>Perry Hall</b>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Richard Nathaniel Edwards</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna Mary Carroll</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>   |  | 16b. SOCIAL SECURITY NO. <b>577-24-5485</b>   |  | 17. INFORMANT ADDRESS <b>Grace Harple 4112 Lachloman Dr. Perry Hall, Md. 21236</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4275</b> IMMEDIATE CAUSE (a) <b>cardiac arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>hypoxia</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <b>septr shock</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) |  |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                      |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/4</b> , 19 <b>82</b> , to <b>1/11</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>1/11</b> , 19 <b>82</b> , and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |   |  |
| 22b. SIGNATURE <b>Robert J. Garver, Jr.</b> DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>   |  |   |  | 22c. DATE SIGNED <b>1/11/82</b>  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>GARVER</b>   |  |   |  | 22e. ADDRESS <b>JOHNS HOPKINS HOSPITAL DEPT. OF MED.</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>  |  | 23b. DATE <b>1/11/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE   |  |
| 24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b> ADDRESS <b>Balto., Md.</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>JAN 19 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Frances Jan. Nathan</b>   |  |



100% COTTON FIBER

100% COTTON FIBER

GRAYER

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FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 3 7 8

REG. NO.

|  |   |   |  |   |  |
|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>MARGARET PLUNKETT</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JAN. 6, 1982</b>                           |   | 2b. HOUR<br>M  |
| 3. SEX<br><b>FEMALE</b>  | 4. RACE<br><b>WHITE</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11/11/11</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b> YRS  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD                              |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>CITY HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b> | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>OWN HOME</b>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE<br><b>MARYLAND</b>  |   |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOSEPH WHITEFIELD</b>   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>KATHERINE BRYSON</b>             |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>N.A.</b>   |  | 17. INFORMANT<br><b>BETTIMORE, MD. 21206</b><br><b>MRS. BETTY PRESTON, 4757 CHATFORD AVE.</b> |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary Failure</b><br><b>1539</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Metastatic Carcinoma of colon</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |   |   |  |   |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>          | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)                |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/16</b> , 19 <b>81</b> , to <b>1/6</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>1/6</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                      |   |   |  |   |  |
| 22b. SIGNATURE<br><b>H. Parnes MD</b>  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>1/6/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>PARNES</b>   |   | 22e. ADDRESS<br><b>Beth City Hosp.</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |   | 23b. DATE<br><b>1/11/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>FROSTBURG MEM. PK.</b>                               |  |
| 23d. LOCATION<br>CITY OR TOWN<br><b>FROSTBURG ALLEGANY, MD.</b>  |   | 23e. COUNTY<br><b>ALLEGANY</b>  |  | 23f. STATE<br><b>MD.</b>  |  |

21. GENERAL DIRECTOR

NAME

ADDRESS

22. GENERAL DIRECTOR

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36. GENERAL DIRECTOR



TO THE  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| Item 1 g653 1/21/82 gj  |  | STATE OF MARYLAND   |   | 8 2 0 1 3 7 9  |  |
| FOR Item #1 Film G563 1/26/82   |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |   |  |  |
| 1 - STATE REGISTRAR   |  | CERTIFICATE OF DEATH  |   | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <u>James Woodrow J. POFF</u>  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><u>1 6 82</u>   |   | 2b. HOUR<br><u>6 30 P.M.</u>   |  |
| 3. SEX<br><u>Male</u>   | 4. RACE<br><u>White</u>  | 5. DATE OF BIRTH MONTH DAY YEAR<br><u>April 24, 1914</u>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>67</u> YRS.                                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>Virginia</u>  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>Baltimore City</u> MD.                    |  |
| 10. CITY OR TOWN OF DEATH<br><u>Baltimore</u>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH ESTABLISHMENT, GIVE STREET ADDRESS)<br><u>Good Samaritan Hospital</u> | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>Technician</u>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>Refrigeration</u>                            |  |
| 13a. STATE<br><u>Virginia</u>   | 13b. COUNTY<br><u>Roanoke</u>  | 13c. CITY OR TOWN<br><u>Roanoke</u>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><u>727.1 Whistler Drive S.W.</u>                              |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><u>Reiley Poff</u>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><u>Lucy Mills</u>   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><u>No</u>   | 16b. SOCIAL SECURITY NO.<br><u>245 07 7101</u>   | 17. INFORMANT ADDRESS<br><u>Oakey Funeral Home, Roanoke, Va.</u>  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac arrest</u><br><u>5150</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>Unknown</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Severe pulmonary fibrosis / Renal failure</u><br>pand pneumonia |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>20 minutes</u>  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |   |  |  |
| 19a. DATE OF OPERATION<br><u>12/28/81</u>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>Pulmonary fibrosis + pneumonia</u>   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><u>P.M. 19</u>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>12/19</u> , 19 <u>81</u> , to <u>1/6</u> , 19 <u>82</u> , that (1) <input checked="" type="checkbox"/> I saw the deceased alive on <u>1/6</u> , 19 <u>82</u> , and that in my <u>hour</u> opinion death occurred on the date and hour and from the causes stated above. (If we did (did not) view the body after death.)  |  |   |   |  |  |
| 22b. SIGNATURE<br><u>Lynn M. Billingsley MD</u>   |  | DEGREE<br><u>MD</u>   |   | 22c. DATE SIGNED<br><u>1/6/82</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>LYNN M. BILLINGSLEY MD</u>  |  | 22e. ADDRESS<br><u>GOOD SAMARITAN HOSPITAL<br/>5501 LEECH AVENUE BLVD. BALTIMORE MD 21239</u>   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><u>Burial</u>   | 23b. DATE<br><u>1/10/82</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Sherwood Memorial</u>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Salem, Va.</u>                      |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>Henry W. Jenkins &amp; Sons Co.</u><br>ADDRESS<br><u>4905 York Road Balto., Md. 21212</u>  |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><u>JAN 8 1982</u> <u>Thomas J. Nathan</u>   |   |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 3 8 0

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|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO.  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | 2a. DATE OF DEATH   |  |
| FIRST MIDDLE LAST<br>Antonio N Polito  |  | MONTH DAY YEAR<br>1 12 82   |  |
| 2. SEX<br>M  |  | 2b. HOUR<br>0100A M   |  |
| 3. RACE<br>W   |  | 3. AGE (IN YEARS LAST BIRTHDAY)   |  |
| 4. DATE OF BIRTH<br>MONTH DAY YEAR<br>11 10 02   |  | 79 YRS.   |  |
| 5. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>ITALY  |  | 6. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 7. IF UNDER 24 HRS.   |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore City  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Agnes Hospital   |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>RET. FIREMAN  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>R.I. NAT. GUARD  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md   |  | 13b. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 13c. CITY OR TOWN<br>Anne Arundel  |  | 13d. STREET ADDRESS<br>712 Andover Rd.  |  |
| 13e. CITY OR TOWN<br>Linthicum   |  | 13f. STATE<br>Md.   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>AMEDAO POLITO  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MARIA ROSA TORRUSIO  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.<br>035-05-2400   |  |
| 17. INFORMANT (WIFE)<br>ADDRESS<br>CONCETTA ZAMPIELLO POLITO SAME AS #13   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Generalized brain atrophy</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Sublethal low pressure hydrocephalus</u> |  |
| 19. DATE OF OPERATION<br>1979  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Low Pressure Hydrocephalus -  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 20b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |
| 21a. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21b. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>1977</u> , to <u>Jan</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE<br><u>Alexander D. Jones</u><br>DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  |
| 22c. DATE SIGNED<br><u>Jan 12 1982</u>   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ALEJANDRO MEXIA MD   |  |
| 22e. ADDRESS<br>1900 Sulphur Sp Rd 21227   |  | 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  |
| 23b. DATE<br>1/16/82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>ST. FRANCIS CEM.  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>PAWTUCKET R.I.   |  | 24. FUNERAL DIRECTOR<br>NAME<br>E. BARNES   |  |
| 24a. ADDRESS<br>21018 BENSON, MD.  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 12 1982  |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>James J. Nathan</u>   |  |   |  |





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 3 8 1

REG. NO.

1- FOR  
STATE  
REGISTRAR

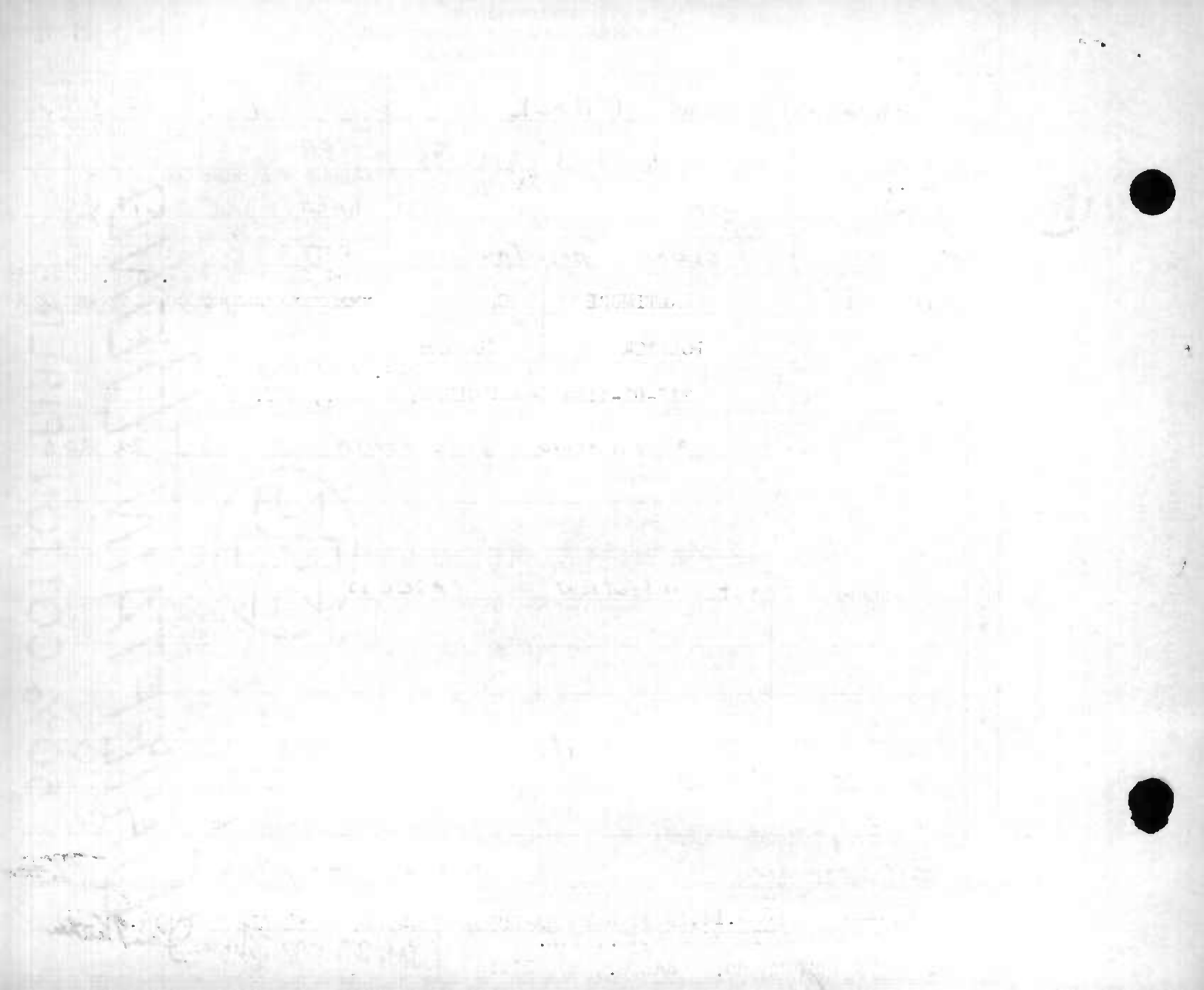
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|--|--|---|--|---|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>ABRAHAM JONAS POLLACK   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1 13 82                             |   |   | 2b. HOUR<br>5:15 AM  |  |   |  |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>CAUCASIAN  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3 12 93   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>88 YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |  |
| 7a. BALTIMORE, MD<br>BALTO., MD  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SINAI Hospital |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>CUTTER   |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>CLOTHING  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD   |  |   | 13b. COUNTY<br>BALTIMORE   |   | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13d. STREET ADDRESS<br>4004 GLENGYLE AVE. APT. C 21215 |   |  |  |
| 14. FATHER'S NAME<br>FIRST MAYER MIDDLE POLLACK LAST   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST HANNAH MIDDLE PAUL LAST                  |   |   |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES  |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WWI 213-01-1194 |   | 17. INFORMANT<br>MRS. ANNA POLLACK  |  |  |   | 17. ADDRESS<br>4004 GLENGYLE AVE., APT. C #21215 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) ASPIRATION PREG MONIA<br>5070<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>22 20 H |  |   |  |   |   |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>Urinary tract infection ASCVD  |  |   |  |   |   |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                           |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                 |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)                  |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)     |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/12 1982 to 1/13 1982, that (I) (we) lost<br>saw the deceased alive on 1/13 1982, and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.            |  |   |  |   |   |  |  |   |  |  |
| 22b. SIGNATURE<br>W. Zitzmann  |  |   | DEGREE   |   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>1/13/82   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ZITZMANN  |  |   | 22e. ADDRESS<br>SINAI Hospital   |   |   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) BURIAL  |  |   | 23b. DATE<br>JAN. 14, 1982   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>BETH HAMEDROSH HAGODOL ROSEDALE BALTO.                    |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE             |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME SOL LEVINSON & BROS., INC.<br>ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215  |  |   | 25a. DATE RECEIVED BY REGISTRAR<br>JAN 20 1982                             |   |   | 25b. REGISTERED BY<br>JAN 20 1982  |  |   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 3 8 2

REG. NO.

|  |   |  |   |  |
|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JOHN WESLEY POLLOCK</b>   |   | 2a. DATE OF DEATH<br>MONTH <b>1</b> DAY <b>22</b> YEAR <b>82</b>   |   | 2b. HOURS<br><b>2:05</b> AM  |
| 3. SEX<br><b>MALE</b>  | 4. RACE<br><b>BLACK</b>   | 5. DATE OF BIRTH<br>MONTH <b>12</b> DAY <b>02</b> YEAR <b>02</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b>   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>ARKANSAS</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. CITY</b> MD.   |
| 10. CITY OR TOWN OF DEATH<br><b>CITY</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>LUTHERAN HOSP</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>CUSTODIAN</b>            | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Simpkins Industries</b>  |
| 13a. STATE<br><b>MD</b>  | 13b. COUNTY   | 13c. CITY OR TOWN<br><b>BALTO.</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST <b>CHARLES</b> MIDDLE <b>POLLOCK</b> LAST <b>POLLOCK</b>  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>ANNIE</b> MIDDLE <b>P.</b> LAST <b>LEWIS</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>                  |  |
| 16b. SOCIAL SECURITY NO.<br><b>217097415</b>   |   | 17. INFORMANT <b>MRS. FLORENCE M. POLLOCK</b> ADDRESS <b>BALTIMORE, MARYLAND 21229 AVE.</b>  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b><br><b>4360</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>Pneumonia, Metastatic carcinoma of prostate</b>   |   |  |   |  |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/22/82</b> to <b>1/22/82</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |   |  |   |  |
| 22b. SIGNATURE<br><b>[Signature]</b>   | DEGREE  |  | 22c. DATE SIGNED<br><b>1/22/82</b>  |  |
| 22d. PHYSICIAN'S NAME (LAST, FIRST)<br><b>KYAW NYUNT</b>   |   | 22e. ADDRESS<br><b>LUTHERAN HOSPITAL</b>   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>BURIAL</b>   | 23b. DATE<br><b>1-27-82</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>WESTERN STAR CEM.</b>   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE COUNTY, MARYLAND</b>                 |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>BALTIMORE</b> ADDRESS <b>MARYLAND 21216</b>  |   | 25a. DATE REC'D. BY REGISTRAR <b>JAN 25 1982</b>   |   |  |
| Herbert E. Nutter Funeral Home   |   | 3635 IV NORTH AVE.   |   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-1234.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 3 8 3

REG. NO.

|  |   |  |   |   |  |
|--|---|--|---|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>WEYMAN HOWELL POMEROY</b>  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 6 82</b>                                |   | 2b. HOUR<br>MIN.<br><b>6:00 AM</b>                               |
| 3 SEX<br><b>Male</b>   | 4 RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7/17/15</b>   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>YRS<br><b>66</b>  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Georgia</b>   | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore, Maryland</b> MD.                       |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Wyman Park Health System</b> |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>American Seaman</b> |   | 12b KIND OF BUSINESS OR INDUSTRY<br><b>Shrimp</b>                |
| 13a USUAL RESIDENCE (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS BEFORE ADMISSION)<br>13a. STATE<br><b>Georgia</b>  |   |  | 13b. CITY OR TOWN<br><b>Darien</b>  | 13c. STREET ADDRESS<br><b>P.O. Box 1109 31305</b>   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Jesse Howell Pomeroy</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Pearl Amelia Davis</b>   |   |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>   |   | 16b SOCIAL SECURITY NO.<br><b>260-09-2993</b>  |   | 17 INFORMANT<br>ADDRESS<br><b>Lyons, Ga.</b><br><b>Pearl A. Sharpe 104 W. Wesley Avenue</b> |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiorespiratory arrest</b><br>1619<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>metastatic cancer</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Cancer of larynx</b>                              |   |  |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>TRACHEAL - ESOPHAGEAL FISTULA</b>  |   |  |   |   |  |
| 19a. DATE OF OPERATION<br><b>12/7/81</b>   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Dysphagia</b>   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>        |  |
| 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |  |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)              |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Jan. 5 82</b> , to <b>Jan. 6 82</b> , that (I) (we) last saw the deceased alive on <b>Jan. 5 82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |  |   |   |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>FLORANTE S. AUSTRIA</b>  |   | DEGREE<br><b>M.D.</b>  |   | 22c. DATE SIGNED<br><b>1/6/82</b>   |  |
| 22d. ADDRESS<br><b>3100 WYMAN PARK DR. BALTO MD</b>  |   |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Removal/Burial</b>  |   | 23b. DATE<br><b>01-09-82</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lyons City Cemetery</b>                            |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Lyons Toombs Georgia</b>  |   |  |   |   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Hubbard Funeral Home, Inc.</b>   |   | BALTO., Md. ADDRESS<br><b>21229 4107 Wilkens Ave.</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 7 1982</b>  |  |

BP

University of California

San Francisco, California  
March 15, 1962  
Dear Mr. [Name]  
I am writing to you in response to your letter of March 10, 1962, regarding the [Topic]. I am sorry that I cannot provide a more definitive answer at this time, but the [Topic] is still under review. I will be sure to contact you again as soon as a final decision has been reached.

Sincerely,  
[Signature]

Very truly yours,  
[Signature]

1/10/62  
[Signature]

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 0 1 3 8 4  
CERTIFICATE OF DEATH

FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |              |   |                   |  |            |   |                           |   |  |
|---|--|--|--------------|---|-------------------|--|------------|---|---------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST<br>WALTER  | MIDDLE<br>R. | LAST<br>POOLE, SR.  | 2a. DATE OF DEATH |  | MONTH<br>1 | DAY<br>27   | YEAR<br>82                | 2b. HOUR<br>8:20 P M  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White   |              | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>May 5, 1908   |                   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>73  |            | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |                           | IF UNDER 24 HRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U S A  |              | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                     |            |   |                           |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Lutheran Hospital |              |   |                   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Stockman   |            | 12b. KIND OF BUSINESS OR INDUSTRY<br>Medical  |                           |   |  |
| 13a. STATE<br>Maryland  |  |  |              | 13b. COUNTY   |                   | 13c. CITY OR TOWN<br>Balto   |            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                           | 13e. STREET ADDRESS<br>311 - Nottingham Rd.   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Thomas L. Poole   |  |  |              | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Town  |                   |  |            |   |                           |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO yes  |  |  |              | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>1927-36  |                   | 17. INFORMANT<br>Milton C. Amos, Jr.   |            | ADDRESS<br>311 Nottingham Rd.   |                           |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiac Arrest<br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) myocardial infarction<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |  |              |   |                   |  |            |   |                           | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |              |   |                   |  |            |   |                           |   |  |
| 19a. DATE OF OPERATION  |  |  |              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                   |  |            | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                           | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  |  |              | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |            |   |                           |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  |              | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |            |   |                           |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/26, 19 82, to 1/27, 19 82, that (I) (we) last saw the deceased alive on 1/27, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (I) did not view the body after death.) |  |  |              |   |                   |  |            |   |                           |   |  |
| 22b. SIGNATURE<br>[Signature]<br>DEGREE<br>MD   |  |  |              |   |                   | 22c. DATE SIGNED<br>1/27/82  |            |   | 22d. ADDRESS<br>[Address] |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |  |              | 23b. DATE<br>1/30/82  |                   | 23c. NAME OF CEMETERY OR CREMATORY<br>New Cathedral Cemetery                   |            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Md.                                    |                           |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Witzke Catonsville Funeral Home, P.A. 21228   |  |  |              | 25a. DATE REC'D. BY REGISTRAR<br>JAN 29 1982  |                   |  |            | 25b. REGISTRAR'S SIGNATURE<br>[Signature]   |                           |   |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 3 8 5

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |  |   |   |   |  |
|---|--|---|--|---|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Elmer August POPE</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>01-28-82</b>                 |   | 2b. HOUR<br><b>5:30A.</b> <sup>M</sup>   |   |   |   |  |
| 3. SEX<br><b>male</b>   |  | 4. RACE<br><b>white</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>05-29-1905</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b> YRS.   |   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD                                |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore City</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>5 E. Randall Street</b> |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Machinist</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY   |   |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |   |  |
| 13e. STREET ADDRESS<br><b>5 E. Randall Street</b>   |  |   |  |   |  |   |   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Harry C. Pope</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Louise ----- Hienmiller</b>   |  |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>705-05-3628</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Alice Pope (wife) 5 E. Randall Street</b>  |  |   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Oat-cell carcinoma of right lung</b><br><b>1629</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>CONDITIONS, IF ANY, WHICH<br>GAVE RISE TO IMMEDIATE<br>CAUSE (a), STATING THE<br>UNDERLYING CAUSE LAST                   |  |   |  |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>6 months</b>              |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |  |   |  |   |   |   |  |
| 19a. DATE OF OPERATION<br><b>none</b>   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING<br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)<br><b>none</b>  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |
| 22a. I certify that (I) (the informant) attended the deceased from <b>January 3, 1957</b> to <b>January 28, 1982</b> , that (I) <del>two</del> <sup>saw</sup> the deceased alive on <b>January 26, 1982</b> , and that in (my) <del>own</del> <sup>own</sup> opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> <sup>did</sup> (did not) view the body after death. |  |   |  |   |  |   |   |   |  |
| 22b. SIGNATURE<br><b>C. C. Chiu</b>   |  |   | DEGREE<br><b>M.D.</b>  |   |  | 22c. DATE SIGNED<br><b>01-28-82</b>   |   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>C. C. Chiu, M.D.</b>  |  |   | 22e. ADDRESS<br><b>1 E. Randall Street, Baltimore, Md. 21230</b>       |   |  |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |   | 23b. DATE<br><b>Feb. 1, 1982</b>                                       |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Meadowridge Mem Park</b>                    |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Dorsey Howard Co. Maryland</b> |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>McCully Funeral Home, 130 E. Fort Ave. Balto. Md.</b>  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 1 1982</b>                     |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Thomas J. Van Kester</b>                                       |   |   |  |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO. 8 2 0 1 3 8 6  |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  |   |  |   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Leon L. POTEE, Sr.   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>January 16, 1982  |  | 2b. HOUR<br>M   |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Sept. 17, 1922   |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.<br>59 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>South Baltimore General Hospital |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Welder   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Union  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13e. STREET ADDRESS<br>3706 West Bay Avenue,  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Charles David Potee   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Frances Marie Schline   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>Yes   |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>WW 39   |  | 17. INFORMANT ADDRESS<br>Catherine J. Potee Same as #13   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4100 } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Acute myocardial infarct.<br>(c) Arteriosclerotic coronary atherosclerosis } DUE TO, OR AS A CONSEQUENCE OF |  |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>second |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b).   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-7-80, to 1-19-82, that (I) (we) lost saw the deceased alive on 7-16-81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br>Laurence R. Gallagher, M.D.  |  |   |  | DEGREE<br>NO ATTENDING PHYSICIAN MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  | 22c. DATE SIGNED<br>1-19-82   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Laurence R. Gallagher, M.D.   |  |   |  | 22e. ADDRESS<br>3455 Wilkens Ave. Balto. Md. 21229  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>1/20/1982  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Crownsville Vet. Cem.   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Crownsville, A. A. Co., Md.  |  |
| 24. FUNERAL DIRECTOR NAME<br>McCully Funeral Home  |  |   |  | 24b. ADDRESS<br>Balto. Md., 21225<br>237 E. Patapsco Ave.,  |  | 25a. DATE REC'D. BY REGISTRAR (25b. REGISTRAR'S SIGNATURE)<br>JAN 22 1982 James J. Nathan                               |  |

CHIEFMAN



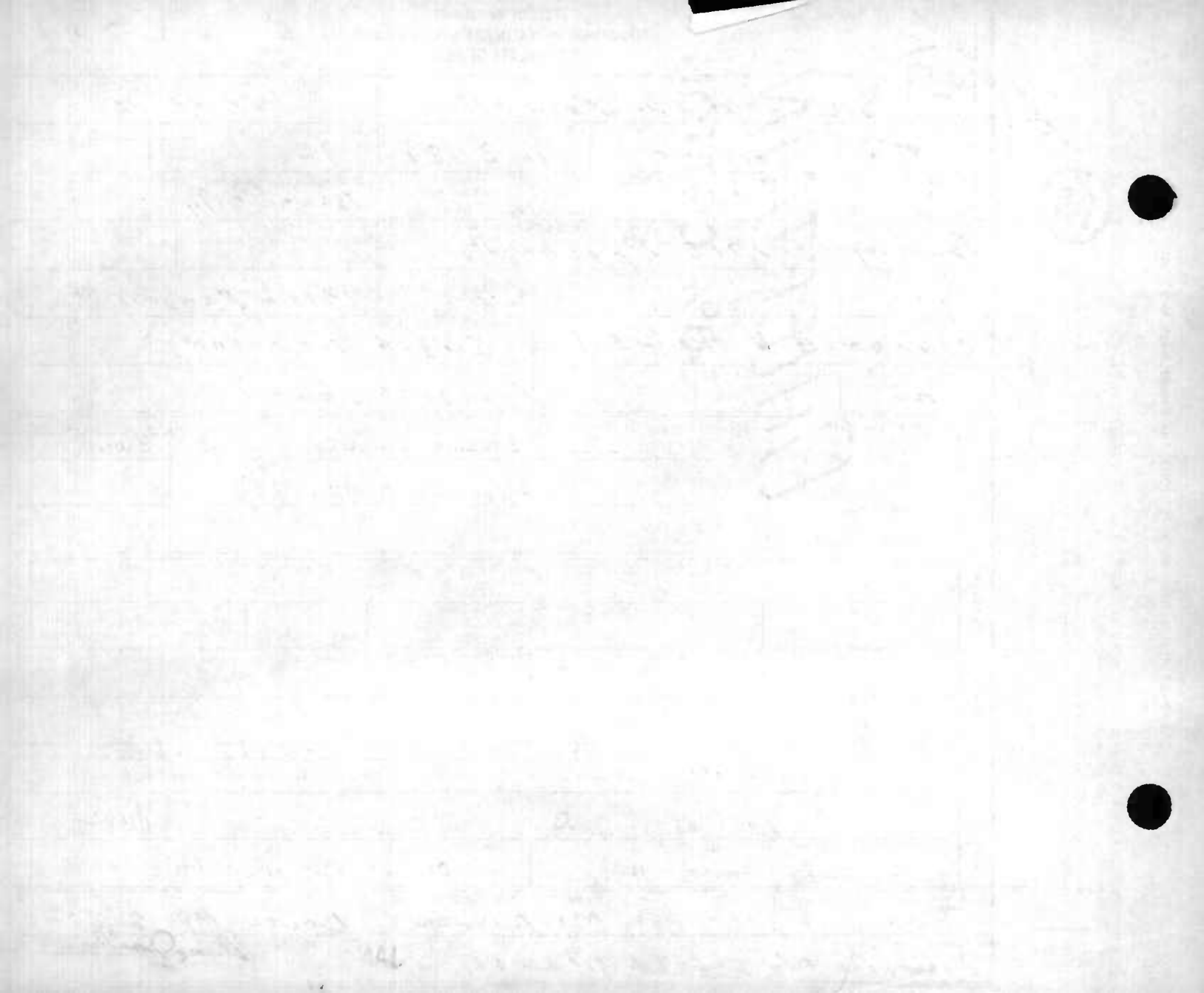
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the Registrar with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 8 2 0 1 3 8 7<br>REG. NO.   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>BRAXTON D. Powell</b>   |  |  |  | 1 18 82 M   |  |   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>negro</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>11 3 84</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>92</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1718 Payson St.</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN<br><b>MD</b>   |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>1718 N Payson St.</b>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>CLARENCE H Powell</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>SUE B Korman</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>no</b>   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS<br><b>CLARENCE Powell</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CHADIAL FAILURE</b><br><b>4029</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>HYPERTENSIVE ART CVD</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 weeks</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>July 5</b> , 19 <b>79</b> , to <b>JAN 18</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>12/31/81</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.             |  |  |  |   |  |   |  |
| 22b. SIGNATURE <b>Kennard Yaffe M.D.</b> DEGREE  |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED <b>1/18/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>KENNARD YAFFE M.D.</b>  |  |  |  | 22e. ADDRESS <b>5501 FOREST PARK AVE</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  | 23b. DATE <b>1/20/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>MT AUBURN</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO MD 2.2.30</b>  |  |
| 24. FUNERAL DIRECTOR NAME <b>Marshall A. Hays</b> ADDRESS <b>636 N. 1st St</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>JAN 20 1982</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>Thane</b>   |  |



8 910 81 37  
 RELEASED NON-MED DR. KORELL  
 TO HOSPITAL OR ATTENDING PHYSICIAN: The low request, that in cases be received within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH - 16 50M 1/81  
 (VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 8 2 0 1 3 8 8   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  | REG. NO.  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ELLEN MAE POWELL</b>   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JANUARY 7, 1982</b>   |  | 2b. HOUR<br><b>2:56 PM</b>  |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>BLACK</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 23 26</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>55</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>SOUTH CAROLINA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEKEEPING</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>UNIV. HOSP.</b>   |  |
| 13a. STATE<br><b>MD</b>   |  |  |  | 13b. COUNTY<br><b>BALTO.</b>  |  | 13c. INSIDE CITY LIMITS?<br><b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>SIMON JAMES</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MITTIE DRAKEFORD</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>  |  |  |  | 16b. SOCIAL SECURITY NO<br><b>214-22-5585</b>   |  | 17. INFORMANT ADDRESS<br><b>GEORGE B. JAMES 2913 KIRK AVENUE</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I: DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Intractable hypertension</b><br><b>45-89</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost           |  |  |  |   |  |   |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 70a. AUTOPSY?<br><b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>            |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                             |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>1/7/82</b> , 19____, to <b>1/7/82</b> , 19____, that (I) <del>viewed</del> lost the deceased alive on <b>1/7/82</b> , 19____, and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above (I) <del>viewed</del> (I) <del>did not</del> view the body after death. |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>James P. [Signature]</b>   |  |  |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>1/7/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JOHN W. [Signature]</b>   |  |  |  | 22e. ADDRESS<br><b>JOHNS HOPKINS HOSPITAL</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>1/14/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE CEM.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MD</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>WM. C. MARCH</b>   |  |  |  | ADDRESS<br><b>F/H 1101 E. NORTH AVENUE</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 11 1982</b>   |  |
|   |  |  |  | REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |   |  |



13 13 01 6

WINTER

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Page 4 of 6

Page 4 of 6

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |   |  |  |   |   | REG. NO. 8 2 0 1 3 8 9   |  |  |  |
|--|--|---|--|--|---|--|--|---|---|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  |  |   |  |  |   |   |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>BERTHA LERLYNE PREIS   |  |   |  |  | 2a. DATE OF DEATH<br>MONTH 1 DAY 21 YEAR 82   |  |  |   |   | 2b. HOUR<br>P.M.   |  |  |  |
| 3 SEX<br>Female  |  | 4 RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH 5 DAY 19 YEAR 94 |   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>87 YRS.                         |   |   | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>       |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                    |   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>2021 Griffis Avenue |  |  |   |  |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>Maryland   |  |   |  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore                                     |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>2021 Griffis Avenue 21230 |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William Schafer  |  |   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Lula Bingle  |  |  |   |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO  |  |   |  |  | 16b. SOCIAL SECURITY NO.<br>212-01-9154   |  | 17. INFORMANT ADDRESS<br>Joseph W. Preis 2025 Griffis Avenue 21230 |   |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u><br><u>4029</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Ventricular ARRHYTHMIA</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(c) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) |  |   |  |  |   |  |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>About 1 yr.</u>         |  |  |  |
| 19a. DATE OF OPERATION   |  |   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  |   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/10</u> , 19 <u>80</u> , to <u>1/21</u> , 19 <u>82</u> , that (I) (we) lost<br>saw the deceased alive on <u>11/16</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did not) view the body after death.  |  |   |  |  |   |  |  |   |   |  |  |  |  |
| 22b. SIGNATURE<br><u>S. P. Mundra</u>  |  |   |  |  | DEGREE<br><u>MD</u><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |   |   | 22c. DATE SIGNED<br><u>1/23/82</u>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>S. P. Mundra, MD.   |  |   |  |  | 22e. ADDRESS<br>203 E. Patapsco Avenue 21225  |  |  |   |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |   |  |  | 23b. DATE<br>1/25/82  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park Cemetery         |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland           |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Hubbard Funeral Home, Inc.   |  |   |  |  | 24b. ADDRESS<br>4107 Wilkens Ave.   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 25 1982                       |   |   | 25b. REGISTRAR'S SIGNATURE<br><u>Frances Jean Nathan</u>                   |  |  |  |

BP

STATE OF MARY

95019 V. 11003

DMC/ W. 11003

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 3 9 0

REG. NO.

|   |  |   |   |   |                                  |  |  |
|---|--|---|---|---|----------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>WILLIAM D PRICE</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 28 82</b> |   | 2b. HOUR<br>AM PM<br><b>1 AM</b> |  |  |
| 3. SEX<br><b>M</b>  |  | 4. RACE<br><b>BLK</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 7 35</b>   |                                  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>46</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>No. Carolina</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>CITY</b> MD   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI</b> |   |   |                                  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>PAINTER</b>   |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>PAINTER</b>   |  |   |   |   |                                  |  |  |
| 13a. STATE<br><b>Md</b>   |  | 13b. COUNTY<br><b>BALTO.</b>  |   | 13c. CITY OR TOWN<br><b>BALTO.</b>  |                                  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 13e. STREET ADDRESS<br><b>947 ARGONNE DRIVE</b>   |  |   |   |   |                                  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Rosa Simpson</b>   |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Rosa Simpson</b>  |                                  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>246-48-0241</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Wilhelmina Price 947 Argonne Dr.</b>   |                                  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Resp. failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>70 widespread metastases</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |   |   |   |                                  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a   |  |   |   |   |                                  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |                                  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/22 1981</b> to <b>1/28 1982</b> , that (I) (we) lost<br>saw the deceased alive on <b>1/28 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death.                           |  |   |   |   |                                  |  |  |
| 22b. SIGNATURE<br><b>John Gordon</b>  |  | DEGREE<br><b>MD</b>   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |                                  | 22c. DATE SIGNED<br><b>1/25/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JOHN GORDON</b>   |  | 9052  |   | 22e. ADDRESS<br><b>SINAI Hosp</b>   |                                  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>2-2-82</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Church Cem.</b>  |                                  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Fayetteville N.C.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>JAS. A. MORTON &amp; SONS</b>  |  | ADDRESS<br><b>1701 LAURENS</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 29 1982</b>   |                                  |  |  |
|   |  |   |   | REGISTRAR'S SIGNATURE<br><b>Francis J. Nathan</b>   |                                  |  |  |

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Items #18a-22a Film G565 3/5/82 PC

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 2 0 1 3 9 1

|  |         |  |  |   |  |  |  |                            |  |                          |  |                                      |  |      |  |   |  |                           |  |
|--|---------|--|--|---|--|--|--|----------------------------|--|--------------------------|--|--------------------------------------|--|------|--|---|--|---------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         | FIRST  |  | MIDDLE  |  | LAST   |  | 2a. DATE KNOWN OF DEATH    |  | MONTH                    |  | DAY                                  |  | YEAR |  | 2b. HOUR  |  |                           |  |
| LAURA PRIDGEN  |         |  |  |   |  |  |  | 1-16-82                    |  |                          |  |                                      |  |      |  | 4:09 PM   |  |                           |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS)   |  | IF UNDER 1 YR.   |  | IF UNDER 24 HRS.           |  | 7c. DATE PRONOUNCED DEAD |  | MONTH                                |  | DAY  |  | YEAR  |  |                           |  |
| female   | black   | 2-8-32   |  | 49 YRS.   |  |  |  |                            |  | 1-21-82                  |  |                                      |  |      |  |   |  |                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?                             |  | 8. MARRIED  |  | NEVER MARRIED  |  | WIDOWED                    |  | DIVORCED                 |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |      |  |   |  |                           |  |
| Wilson, N.C.   |         | yes  |  |   |  |  |  |                            |  |                          |  | Baltimore City                       |  |      |  |   |  |                           |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY                        |  |                            |  |                          |  |                                      |  |      |  |   |  |                           |  |
| Baltimore  |         | 131 Aisquith Street (N) Apt 10D                          |  | none  |  |  |  |                            |  |                          |  |                                      |  |      |  |   |  |                           |  |
| 13a. STATE   |         | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?                                 |  | 13e. STREET ADDRESS        |  |                          |  |                                      |  |      |  |   |  |                           |  |
| Maryland   |         |  |  | Baltimore   |  | YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 131 N. Aisquith Street     |  |                          |  |                                      |  |      |  |   |  |                           |  |
| 14. FATHER'S NAME  |         | 15. MOTHER'S MAIDEN NAME                                 |  |   |  |  |  |                            |  |                          |  |                                      |  |      |  |   |  |                           |  |
| Jim Pridgen  |         | Ira Bertha Ellis   |  |   |  |  |  |                            |  |                          |  |                                      |  |      |  |   |  |                           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?   |         | 16b. SOCIAL SECURITY NO.                                 |  | 17. INFORMANT ADDRESS   |  |  |  |                            |  |                          |  |                                      |  |      |  |   |  |                           |  |
| Unkn.  |         |  |  |   |  |  |  |                            |  |                          |  |                                      |  |      |  |   |  |                           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         |  |  |   |  |  |  |                            |  |                          |  |                                      |  |      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |                           |  |
| PART I DEATH WAS CAUSED BY:  |         |  |  |   |  |  |  |                            |  |                          |  |                                      |  |      |  |   |  |                           |  |
| IMMEDIATE CAUSE (a) Asthma   |         |  |  |   |  |  |  |                            |  |                          |  |                                      |  |      |  |   |  |                           |  |
| 4939   |         |  |  |   |  |  |  |                            |  |                          |  |                                      |  |      |  |   |  |                           |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |  |  |   |  |  |  |                            |  |                          |  |                                      |  |      |  |   |  |                           |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.  |         |  |  |   |  |  |  |                            |  |                          |  |                                      |  |      |  |   |  |                           |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |  |  |   |  |  |  |                            |  |                          |  |                                      |  |      |  |   |  |                           |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |  |  |   |  |  |  |                            |  |                          |  |                                      |  |      |  |   |  |                           |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1   |         |  |  |   |  |  |  |                            |  |                          |  |                                      |  |      |  |   |  |                           |  |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?        |  |   |  |  |  |                            |  |                          |  |                                      |  |      |  | 20. AUTOPSY?  |  |                           |  |
|  |         |  |  |   |  |  |  |                            |  |                          |  |                                      |  |      |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                           |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         | 21b. TIME OF INJURY                                      |  | 21c. HOW INJURY OCCURRED                                      |  | 21d. INJURY OCCURRED                                     |  |                            |  |                          |  |                                      |  |      |  | 21e. PLACE OF INJURY  |  | 21f. LOCATION             |  |
|  |         | HOUR A.M. MONTH DAY YEAR                                 |  | P.M. 19   |  |  |  |                            |  |                          |  |                                      |  |      |  | STREET  |  | CITY OR TOWN COUNTY STATE |  |
| 21d. INJURY OCCURRED   |         | 21e. PLACE OF INJURY                                     |  | 21f. LOCATION   |  |  |  |                            |  |                          |  |                                      |  |      |  |   |  |                           |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |         | STREET, FACTORY, FARM, ETC.)                             |  | STREET  |  |  |  |                            |  |                          |  |                                      |  |      |  |   |  |                           |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |  |  |   |  |  |  |                            |  |                          |  |                                      |  |      |  |   |  |                           |  |
| ACTUAL SIGNATURE   |         | TITLE (SPECIFY)  |  | M.D. Assistant  |  | MEDICAL EXAMINER   |  | DATE SIGNED                |  | 1-22-82                  |  |                                      |  |      |  |   |  |                           |  |
| EXAMINER'S NAME  |         | ADDRESS  |  |   |  |  |  |                            |  |                          |  |                                      |  |      |  |   |  |                           |  |
| (TYPE OR PRINT)  |         | Margarita A. Koroll, M.D.                                |  | 11 Penn Street  |  |  |  |                            |  |                          |  |                                      |  |      |  |   |  |                           |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |         | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY                            |  | 23d. LOCATION  |  | CITY OR TOWN               |  | COUNTY                   |  | STATE                                |  |      |  |   |  |                           |  |
| Removal  |         | 2/1/82   |  |   |  |  |  |                            |  |                          |  |                                      |  |      |  |   |  |                           |  |
| 24. FUNERAL DIRECTOR   |         | NAME   |  | ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR                            |  | 25b. REGISTRAR'S SIGNATURE |  |                          |  |                                      |  |      |  |   |  |                           |  |
| Anatomy Board  |         |  |  | Balto., Md.   |  | FEB 8 1982   |  |                            |  |                          |  |                                      |  |      |  |   |  |                           |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY OCCURS, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



Received 2/1/62

Amount paid


Ref. No.

File No.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |   |  |  |  |   |  |   |  | REG. NO. 2 0 1 3 9 2  |  |                  |  |
|--|--|---|--|--|--|---|--|---|--|---|--|------------------|--|
| 1. FOR STATE REGISTRAR   |  |   |  |  |  | 2a. DATE OF DEATH   |  |   |  |   |  | 2b. HOUR         |  |
| DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>ALBERT T. PRIDGEON  |  |   |  |  |  | DATE OF DEATH ESTIMATED MONTH DAY YEAR<br>1 2 19 82   |  |   |  |   |  | HOUR<br>2:25 P M |  |
| 3. SEX<br>male   |  | 4. RACE<br>white  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>March, 28, 1924 57 YRS.  |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  | 7c. DATE PRONOUNCED DEAD  |  | 2d. HOUR  |  |                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |   |  |   |  |                  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1532 Williams St. |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Set up man Western Electric    |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |                  |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>1532 William St. Balto. Md.                            |  |   |  |                  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Albert T. Pridgeon, Sr.   |  |   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Sarah E. Fisher                                   |  |   |  |   |  |                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>Yes   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>W.W. 2   |  | 17. INFORMANT<br>Mrs. Betty Marcianite, 1519 William St. Balto.  |  |   |  | ADDRESS   |  |   |  |                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>4292 Arteriosclerotic cardiovascular disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |   |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |                  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |   |  |  |  |   |  |   |  |   |  |                  |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |   |  |                  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |   |  |                  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |   |  |  |  |   |  |   |  |   |  |                  |  |
| ACTUAL SIGNATURE<br>  |  |   |  | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER   |  |   |  | DATE SIGNED<br>1-3-82   |  |   |  |                  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Ann M. Dixon, M.D.  |  |   |  | ADDRESS<br>111 Penn St.  |  |   |  |   |  |   |  |                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |   |  | 23b. DATE<br>Jan. 6, 1982  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Druidridge Cemetery                                       |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Co. Maryland               |  |                  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>McCully Funeral Home, 130 E. Fort Ave. Balto. Md.  |  |   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 5 1982   |  |   |  |   |  |                  |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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FOR  
1. STATE  
REGISTRAR Amy Florence Prince

REG. NO.

|   |  |  |   |   |  |   |   |
|---|--|--|---|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Amy Florence Prince  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>1/12/82 |   |  | 2b. HOUR<br>7:50 AM   |   |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>White   |   | 5. DATE OF BIRTH MONTH DAY YEAR<br>4/30/11  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>70 YRS.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New York   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore MD.   |   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>South Baltimore General |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOME MAKER                  |   |
| 13a. STATE<br>Md  |  | 13b. COUNTY<br>A.A. Co   |   | 13c. CITY OR TOWN<br>Brooklyn Pk  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Harry Hulse   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Melissa Sarine  |   |   |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES   |  | 16b. SOCIAL SECURITY NO.<br>W.W. II 218 36 0004  |   | 17. INFORMANT<br>Charles W. Prince same as 13 e   |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Congestive Heart Failure<br>4039<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Hypertensive Cardiovascular arteriosclerotic Disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |   |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>Adult onset Diabetes mellitus   |  |  |   |   |  |   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/30/81 to 1/12/82 that (I) (we) saw the deceased (live on 1/12/82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.         |  |  |   |   |  |   |   |
| 22b. SIGNATURE<br>Craig T. Nelson M.D.  |  |  |   | DEGREE<br>M.D.  |  | 22c. DATE SIGNED<br>11/12/82  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Craig T. Nelson M.D.   |  |  |   | 22e. ADDRESS<br>South Baltimore General   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>1/16/82   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Glen Haven Mem Pk   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Glen Burnie A.A. Md.                              |   |
| 24. FUNERAL DIRECTOR<br>NAME Balto Md. 21225<br>George J. Gonce 4001 Ritchie Hwy  |  |  |   | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br>JAN 14 1982 [Signature]   |  |   |   |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

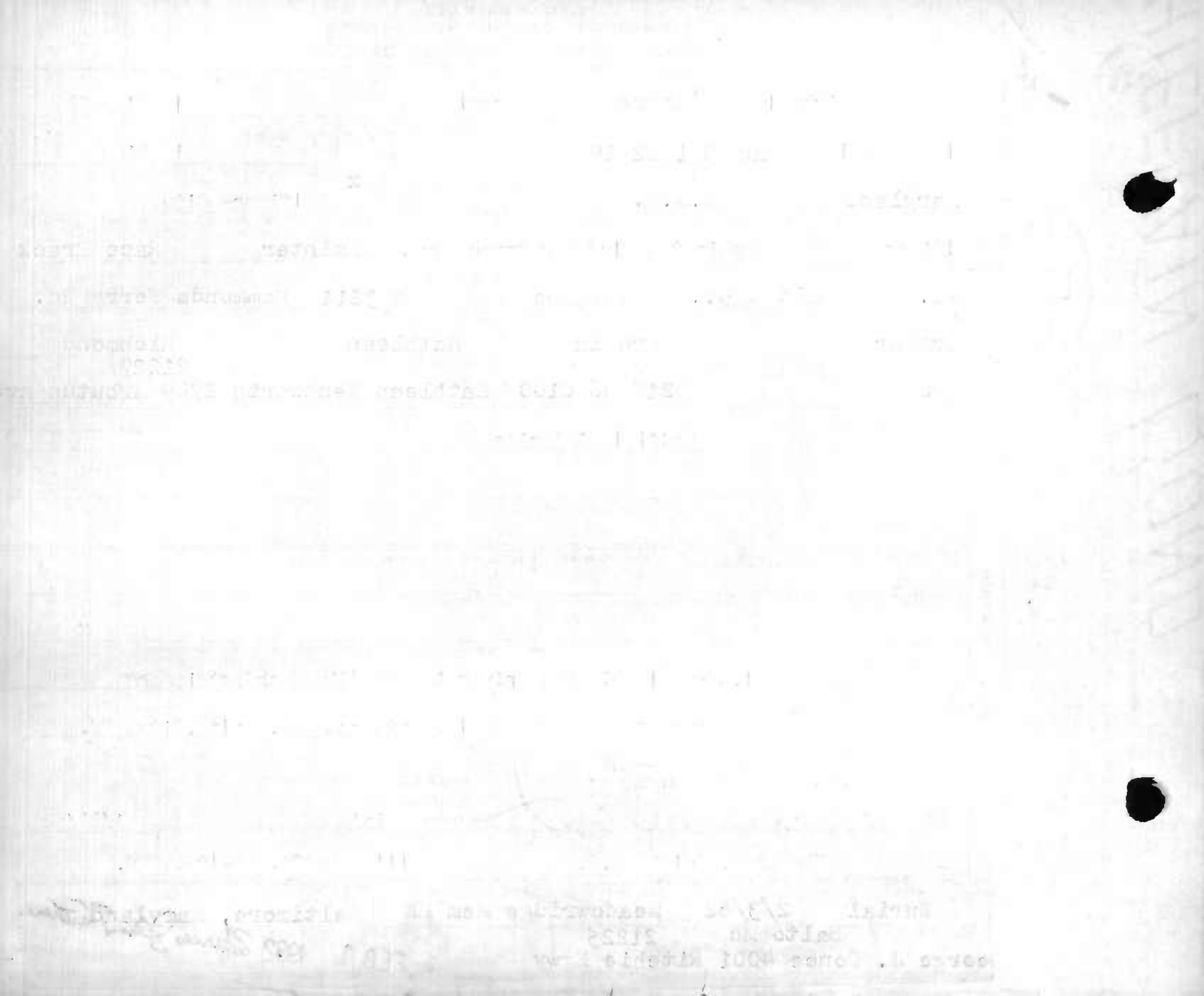
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1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 26

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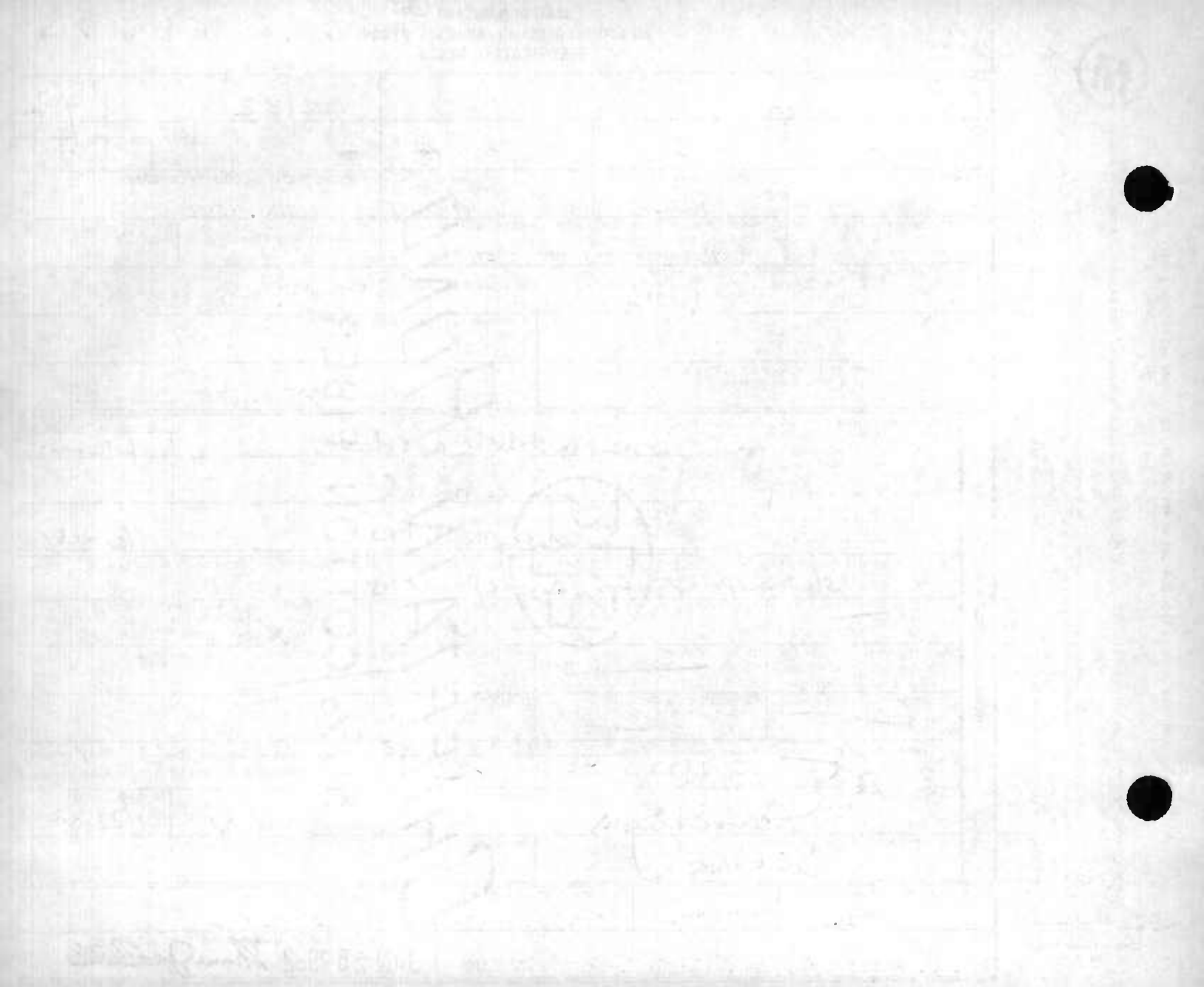
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |   | REG. NO.  |  |
|---|--|--|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)  |  | 2a. DATE OF DEATH  |   | 2b. HOUR  |  |
| FIRST MIDDLE LAST   |  | MONTH DAY YEAR   |   | HOUR MIN.   |  |
| ORA A. PRYOR  |  | 1/22/82  |   | 9:04 PM   |  |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH   |   | 6. AGE (IN YEARS LAST BIRTHDAY)   |  |
| Female  | Black  | MONTH DAY YEAR   |   | YRS.  |  |
|   |  | 9 24 07  |   | 74  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |
| MD  | U.S.A.   |  |   | BALTO. CITY MD  |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |   | 12b. KIND OF BUSINESS OR INDUSTRY  |
| BALTIMORE   | UNION MEMORIAL HOSPITAL  |  |   |   |  |
| 13a. STATE  |  | 13b. COUNTY  | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS  |
| MD  |  | Baltimore  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 305 E. Lafayette Ave.   |  |
| 14. FATHER'S NAME (FIRST MIDDLE LAST)   |  | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)   |   |   |  |
| Robert Johnson  |  | Elizabeth ?  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)   |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT ADDRESS   |  |
| No  |  | N/A  |   | Harold Banks 305 E. Lafayette Ave.  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Severe metabolic acidosis</u><br><u>5579</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if only, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>ischemic bowel</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>encephalitis</u> |  |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>6 hours</u><br><u>1 1/2 weeks</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><u>status epilepticus, encephalitis</u>   |  |  |   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR AM MONTH DAY YEAR   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)    |  |
|   |  | P.M. 19  |   |   |  |
| 21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                    |  |
|   |  |  |   |   |  |
| 22a. I certify that (1) this hospital attended the deceased from <u>1/13</u> , 19 <u>82</u> , to <u>1/22</u> , 19 <u>82</u> , that (1) <u>two</u> lost saw the deceased alive on <u>1/22</u> , 19 <u>82</u> , and that in my opinion death occurred on the date and hour and from the causes stated above, (2) <u>we</u> did (did not) view the body after death.   |  |  |   |   |  |
| 22b. SIGNATURE <u>[Signature]</u>   |  | DEGREE   |   | 22c. DATE SIGNED <u>1/22/82</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>D.E. KING</u>  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |   |   |  |
|   |  | 22e. ADDRESS   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>   |  | 23b. DATE <u>1/28/82</u>   |   | 23c. NAME OF CEMETERY OR CREMATORY <u>King Memorial Park</u>                      |  |
| 23d. LOCATION CITY OR TOWN COUNTY STATE   |  | <u>Balto. Co. MD</u>   |   |   |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE  |   |   |  |
| <u>Wm. C. March F/H, Inc. 1101 E. North Avenue</u>  |  | <u>JAN 25 1982 [Signature]</u>   |   |   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the health officer with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |                               |  |   | 8 2 0 1 3 9 6   |  |  |   |
|--|--|-------------------------------|--|---|---|--|--|---|
| FOR STATE REGISTRAR  |  |                               |  |   | REG. NO.  |  |  |   |
| 1. DECEASED NAME (TYPE OR PRINT) <b>Jerome H. PUMPIAN</b>  |  |                               |  |   | 2a. DATE OF DEATH MONTH DAY YEAR 1 3 82   |  |  |   |
| 3. SEX <b>MALE</b>   |  |                               |  |   | 2b. HOUR 12 <sup>02</sup> P.M.  |  |  |   |
| 4. RACE <b>Cauc.</b>   |  |                               |  |   | 5. DATE OF BIRTH MONTH DAY YEAR 7 22 07   |  |  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>  |  |                               |  |   | 6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS  |  |  |   |
| 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  |                               |  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |   |
| 10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>   |  |                               |  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.  |  |  |   |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SINAI HOSPITAL BALT. Md 21215</b>  |  |                               |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>PRESIDENT</b>  |  |  |   |
| 13a. STATE <b>MARYLAND</b>   |  |                               |  |   | 12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>CLOTHING MANUFACTURER</b>  |  |  |   |
| 13b. CITY OR TOWN <b>BALTIMORE</b>   |  |                               |  |   | 13c. STREET ADDRESS <b>PIMLICO 6103 Pimlico Rd 21209</b>  |  |  |   |
| 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>XX</b>   |  |                               |  |   | 13e. STREET ADDRESS <b>PIMLICO 6103 Pimlico Rd 21209</b>  |  |  |   |
| 4. FATHER'S NAME FIRST MIDDLE LAST <b>SAMUEL PUMPIAN</b>   |  |                               |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>NELLIE MITNICK</b>  |  |  |   |
| 6a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>   |  |                               |  |   | 16b. SOCIAL SECURITY NO. <b>216-05-6715</b>   |  |  |   |
| 17. INFORMANT <b>MRS. BETTYE PUMPIAN</b>   |  |                               |  |   | 17. ADDRESS <b>6103 PIMLICO RD. BALTO., MD 21209</b>  |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiac arrest</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Probable MI</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |                               |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>had carcinoma of thyroid cancer, basilar artery insuff. sick sinus syndrome</b>  |  |                               |  |   |   |  |  |   |
| 19a. DATE OF OPERATION   |  |                               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>X</b> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>X</b> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                               |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)             |  |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |                               |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |
| 22a. I certify that (I) (his hospital) attended the deceased from <b>Jan 3</b> , 19 <b>82</b> , to <b>Jan 3</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>Jan 3</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.       |  |                               |  |   |   |  |  |   |
| 22b. SIGNATURE <b>Philip J. Schwartz MD</b>  |  |                               |  | DEGREE  |   | 22c. DATE SIGNED <b>JAN 3, 1982</b>  |  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>PHILIP JAY SCHWARTZ MD</b>  |  |                               |  | 22e. ADDRESS <b>SINAI Hos (dept of (omm med) Balt, Md 21215</b>     |   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>  |  | 23b. DATE <b>JAN. 4, 1982</b> |  | 23c. NAME OF CEMETERY OR CREMATORY <b>BETH TFILOH</b>               |   | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>                          |  |   |
| 24. FUNERAL HOME OR OTHER INSTITUTION (NAME) <b>SOL LEVINSON &amp; BROS., INC.</b>   |  |                               |  | 25a. DATE REC'D. BY REGISTRAR <b>JAN 7 1982</b>                     |   | 25b. REGISTRAR'S SIGNATURE <b>Frances Jan Nathan</b>                                       |  |   |
| 26. ADDRESS <b>6010 REISTERSTOWN RD. #21215</b>  |  |                               |  |   |   |  |  |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO. 8201397   |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Josephine Queen   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>1 26 82  |  | 2b. HOUR<br>7:25 AM  |  |
| 3. SEX<br>F  |  | 4. RACE<br>Black  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>10 27 15  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>66 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University of Maryland Hosp |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>—   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>—   |  |
| 13a. STATE<br>MD   |  | 13b. COUNTY<br>BALTO  |  | 13c. CITY OR TOWN<br>Baltimore   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>William Thomas  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Mary Blake  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>Unknown   |  |  |  |
| 16b. SOCIAL SECURITY NO.<br>216-32-7015  |  | 17. INFORMANT<br>Rev. Geo. Alexander  |  | ADDRESS 59 Ambo Circle 21220   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiopulmonary arrest<br>1629<br>DUE TO, OR AS A CONSEQUENCE OF (b) oat cell carcinoma<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH     |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION<br>1-26-81  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Airway obstruction tracheostomy   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br>—  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>—   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>— Baltimore MD  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-15, 19 82, to 1-26, 19 82, that (I) (we) last saw the deceased alive on 1-26, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br>Linda Headrich MD  |  |   |  | DEGREE<br>MD   |  | 22c. DATE SIGNED<br>1-26-82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Linda Headrich, MD  |  |   |  | 22e. ADDRESS<br>22 S. Greenest, Baltimore MD 21201   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>1-30-82  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Auburn Cem.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. MD.   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>CHAS. A. RICE FSPA 1300 Eutaw Pl.  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 1 1982  |  |  |  |
|  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br>Thomas J. [Signature]  |  |  |  |

0000 BP

RECEIVED  
JAN 10 1964

TO: DIRECTOR, FBI  
FROM: SAC, NEW YORK  
SUBJECT: [Illegible]

RE: [Illegible]

[Illegible body text]

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 3 9 8

FOR  
1- STATE  
REGISTRAR

REG. NO.

|   |   |   |   |   |  |
|---|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Willie Mae Queen</i>                       |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>1 30 82</i>  |   | 2b. HOUR<br><i>7:30 A.M.</i>                                   |
| 3. SEX<br><i>Female</i>   | 4. RACE<br><i>Black</i>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>6/1/19</i>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>62</i>                      | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 74 HRS<br>HOURS MIN |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>                      | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD. |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>                                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF DECEASED IN A NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br><i>Provident Hospital</i> |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  | 12b. KIND OF BUSINESS OR INDUSTRY                              |
| 13a. STATE<br><i>Md.</i>  | 13b. COUNTY   | 13c. CITY OR TOWN<br><i>Balt.</i>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><i>2016 N. Payson St.</i>                  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Charles Clay</i>                     |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Mary Clay</i>   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>no</i> |   | 16b. SOCIAL SECURITY NO.<br><i>217-05-1947</i>  |   | 17. INFORMANT ADDRESS<br><i>Raymond Queen 3915 Barrington Rd.</i> |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

*Coronary pulmonary Arrest*

DUE TO, OR AS A CONSEQUENCE OF

(b) *Airway Obstruction*

DUE TO, OR AS A CONSEQUENCE OF

(c) *Carcinoma of the Larynx*APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

|  |   |   |   |
|--|---|---|---|
| 19a. DATE OF OPERATION<br><i>1/22/82</i>   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>Airway Obstruction</i> | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)        | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1/21</i> , 19 <i>82</i> , to <i>1/30</i> , 19 <i>82</i> , that (I) (we) lost<br>saw the deceased alive on <i>1/30</i> , 19 <i>82</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |   |   |   |
| 22b. SIGNATURE<br><i>Ronald D. Miles</i>   | DEGREE<br><i>M.D.</i>   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED<br><i>1/30/82</i>  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Ronald D. Miles, M.D.</i>  |   | 22e. ADDRESS<br><i>Provident Hosp.</i>  |   |

|   |                            |  |   |
|---|----------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i> | 23b. DATE<br><i>2/4/82</i> | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Md. Vet. Cem.</i> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Crownsville, Md.</i> |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Charles A. Rice</i>        |                            | 25a. DATE REC'D. BY REGISTRAR<br><i>FEB 5 1982</i>         | 25b. REGISTRAR'S SIGNATURE<br><i>Ronald D. Miles</i>                  |

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

MEMORANDUM

TO :

FROM :

SUBJECT :

DATE :

RE :

1. [Illegible text]

2. [Illegible text]

3. [Illegible text]

4. [Illegible text]

5. [Illegible text]

6. [Illegible text]

7. [Illegible text]

8. [Illegible text]

9. [Illegible text]

10. [Illegible text]

11. [Illegible text]

12. [Illegible text]

13. [Illegible text]

14. [Illegible text]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 2 0 1 3 9 9   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  |   |  | REG. NO.  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>Virginia L. Queensberry</b>   |  |   |  | 2a. DATE OF DEATH   |  | 2b. HOUR  |  |
|   |  |   |  | 1 22 82   |  | 2 22 PM   |  |
| 3. SEX <b>F</b>   |  | 4. RACE <b>B.</b>   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  |
|   |  |   |  | MAY 26 1899   |  | 82 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VIRGINIA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>US</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>CITY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BON SECOURS</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>NURSE</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE <b>MARYLAND</b>  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN <b>BALTIMORE</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 13e. STREET ADDRESS <b>2210 PRESSTMAN ST.</b>   |  | 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME  |  |   |  |
| 14a. FIRST MIDDLE LAST <b>WILLIE WYNN</b>   |  | 15a. FIRST MIDDLE LAST <b>IDA TENSLEY</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>   |  | 16b. SOCIAL SECURITY NO.  |  |
| 16c. ADDRESS <b>ALVIN QUEENSBERRY 2210 PRESSTMAN ST.</b>  |  | 17. INFORMANT   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>BRAINSTEM INFARCTION</b><br><b>4349</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>16 DAYS</b>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>HYPERTENSION</b>   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>JANUARY 8</b> , 19 <b>82</b> , to <b>JANU</b> , 19____, that (1) (we) lost <b>saw</b> the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |
| 22b. SIGNATURE <b>Bruce Kohrn</b> DEGREE <b>MD</b>  |  |   |  | 22c. DATE SIGNED <b>1-22-82</b>   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BRUCE KOHRN, M.D.</b>  |  |
| 22e. ADDRESS <b>2000 W. BALTIMORE ST., BALTIMORE, MD</b>  |  |   |  | 23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>   |  | 23b. DATE <b>1-27-82</b>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY <b>ARBUTUS MEM. PK.</b>  |  |   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>   |  | 24. FUNERAL DIRECTOR <b>ELIZABETH L. PHILLIPS 1721 N. MONROE ST.</b>  |  |
| 25a. DATE REC'D. BY REGISTRAR <b>JAN 25 1982</b>  |  |   |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>   |  |   |  |

SECTION 1

WATER



SECTION 2



SECTION 3



SECTION 4

SECTION 5

SECTION 6



SECTION 7

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Items 18c. Film#G564

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

## CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |   |  |   |  |
|---|--|--|--|---|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Luther Thomas Quick Sr.</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Jan 17 82</b>                              |   |  | 2b. HOUR<br><b>3:40 PM</b>  |   |  |   |  |
| 3 SEX<br><b>Male</b>  |  | 4 RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>July 1, 1900</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b>   |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN<br><b>YRS</b>   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>South Carolina</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. City</b> MD.                                       |   |  |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. PLACE OF BIRTH, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Jenkins Memorial Home<br/>1000 S. Caton Ave. Balt; Md. 21229</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Mach. Oper.</b>              |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Lumber</b>   |   |  |
| 13a. STATE<br><b>Maryland</b>   |  |  | 13b. COUNTY<br><b>A.A.</b>   |   | 13c. CITY OR TOWN<br><b>Glen Burnie</b>                        |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>708 Biddle Road</b> |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Quick</b>   |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Sabar Cope</b>                    |   |  |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>W.W. I 250.28.6281</b> |   | 17 INFORMANT<br><b>Grandson</b>                                |   | ADDRESS<br><b>Glen Burnie Maryland</b>  |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio-pulmonary arrest</b><br><b>5990</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>C.B. Syndrome</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Trans-pelvic catheter &amp; chronic urinary tract infection</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |  |   |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TARDIUM DISEASE OR INJURY GIVEN IN PART 1<br><b>18c Trans-pelvic catheter &amp; chronic urinary tract infection</b>   |  |  |  |   |  |   |   |  |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                     |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                           |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                           |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                      |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)               |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3-25-75</b> , 19____, to <b>1-18-82</b> , 19____, that (I) (we) last saw the deceased alive on <b>1-5-82</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |   |  |   |  |
| 22b. SIGNATURE<br><b>George Angov</b>   |  |  |  |   |  | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>1-18-82</b>   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>GEORGE ANGOV</b>  |  |  |  |   |  | 22e. ADDRESS<br><b>3350 Wilkes Dr. Md. Baltimore</b>  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>Jan. 20, 82</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Mem Pk</b> |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Glen Burnie AA Md.</b>                         |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>AB Jackson</b>   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR (25b. REGISTRAR'S SIGNATURE)<br><b>JAN 18 1982 Frances Sant'Arden</b> |   |  |   |  |
| Singleton Funeral Home, Glen Burnie, Md.  |  |  |  |   |  |   |   |  |   |  |

United States  
1000 E. Cotton Ave. Detroit, Mich. 48202

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 8 2 0 1 4 0 1   |  |
|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  | CERTIFICATE OF DEATH  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  |  | 2a. DATE OF DEATH   |  |
| ROSE V. QUINN  |  |  |  | 1/3/82  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |  |
| Female   |  | White  |  | June 12 <sup>th</sup> , 1889  |  |
| 6. BIRTHPLACE (STATE OR FOREIGN)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  |
| Baltimore, Md.   |  | U.S.A.   |  | 92  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |
| Baltimore  |  | St. Agnes Hospital   |  | Baltimore City, MD.   |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  | 13a. INSIDE CITY LIMITS?  |  |
| Clerk  |  | Insurance Co.  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                   |  |
| 13b. STATE   |  | 13c. CITY OR TOWN  |  | 13e. STREET ADDRESS   |  |
| Md.  |  | Baltimore Catonsville  |  | 308 Greenlow Road   |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES)                                 |  |
| Luke J. Quinn  |  | Rosa C. DeLacy   |  | No  |  |
| 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. |  |
| 212-09-1009A   |  | Catonsville, Maryland, 21228.  |  | IMMEDIATE CAUSE (a) Obstructive jaundice  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?   |  |
| 12/24/81 & 12/23/81  |  | Jaundice Obstructive C Stones  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                   |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                        |  |
| While <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | P.M. 19  |  |   |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)                                     |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |
|  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/14/81, 1981, to 1/3/82, 1982, that (I) (we) lost saw the deceased alive on 1/3, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  | 22b. SIGNATURE  |  |
|  |  |  |  | DEGREE  |  |
|  |  |  |  | 22c. DATE SIGNED  |  |
|  |  |  |  | 1/3/82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | 22e. ADDRESS  |  |
| Nanawati A.  |  |  |  | St. Agnes Hospital  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |
| Burial   |  | 1/6/82   |  | New Cathedral Cemetery  |  |
| 24. FUNERAL DIRECTOR NAME  |  | 24b. ADDRESS   |  | 25. DATE REC'D. BY REGISTRAR (SEE REGISTRAR'S SIGNATURE)  |  |
| Sterling Funeral Estate  |  | 736 Edmondson Ave.   |  | JAN 6 1982  |  |
|  |  | Catonsville, Md. 21228   |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |  |  | 8 2 0 1 4 0 2 |  |
|--|--|--|--|---|--|---|--|--|--|---------------|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | REG. NO.   |  |   |  |   |  |  |  |               |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>LAURA M. RAHM</b>   |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>01 21 82</b>                                |  | 2b. HOUR<br><b>3:00 P.M.</b>   |  |               |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>07 06 02</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79 YRS.</b>                                     |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>         |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD                      |  |  |  |               |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>CATON MANOR NURSING HOME</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>PRODUCTION</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>CHRISTMAS OR-</b>  |  |               |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>   |  |  |  | 13b. COUNTY<br><b>---</b>   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>WILLIAM ZIMMERMAN</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ANNIE UNKNOWN</b>   |  |   |  |  |  |               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>216-10-4431</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>CALVIN R. RAHM 1220 CLEVELAND ST., 21230</b>           |  |  |  |               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>4280 Congestive Heart Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.<br><b>Rt. Hemiplegia, Urinary tract infection</b> |  |  |  |   |  |   |  |  |  |               |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>             |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |  |  |               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8. 19. 81</b> to <b>12. 19. 82</b> , that (I) (we) last saw the deceased alive on <b>1. 15. 19. 82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |  |  |               |  |
| 22b. SIGNATURE<br><b>Sukh Dev Auja</b>   |  |  |  | DEGREE<br><b>M.D.</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |  | 22c. DATE SIGNED<br><b>1. 22. 82</b>   |  |               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SUKH DEV AUJLA, M.D.</b>   |  |  |  | 22e. ADDRESS<br><b>5400 OLD COURT ROAD, 21133</b>   |  |   |  |  |  |               |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>01-25-82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LOUDON PARK</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE CITY MARYLAND</b>          |  |  |  |               |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. 21229</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 22 1982</b>   |  |   |  |  |  |               |  |



WATERGATE CITY

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MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   | 82 01403   |  |   |   |  |
|--|--|---|--|---|--|--|---|---|--|
| FOR<br>1. STATE REGISTRAR  |  |   |  |   | REG. NO.   |  |   |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>GRACE RAIFF</b>   |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 11 82</b>  |  |   | 2b. HOUR<br><b>7:30</b><br>P M  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 13 95</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b><br>YRS.                                 |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>BALTO. Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                    |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>NORTH CHARLES GENERAL</b> |  |   | 12. USUAL OCCUPATION<br>(TYPE OR WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY                               |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   | 13a. STATE<br><b>Md.</b>   |  |   |   |  |
| 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>BALTO.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>2339 McCulloh St</b>                                       |   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James H. Shepard</b>  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary E. Grey</b>   |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>220-30-7264</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Constance Barney Wallington Ave. 4015</b>   |  |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic carcinoma to liver and lung</b><br><b>1991</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Senile Dementia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |  |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |  |   |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>      |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/17</b> , 19 <b>81</b> , to <b>1/11</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>1/11</b> , 19 <b>82</b> , and that in (my (our)) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |   |   |  |
| 22b. SIGNATURE<br><b>A.C. Chauvalit, M.D.</b>  |  |   |  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   | 22c. DATE SIGNED<br><b>1/11/82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>A.C. CHOUVALIT</b>   |  |   |  |   | 22e. ADDRESS<br><b>2724 N. Charles St. Baltimore, Maryland 21218</b>   |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>1-15-82</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem. Park</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO. Md.</b> |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Joseph L. Russ</b>  |  |   |  |   | ADDRESS<br><b>2222 W. North Ave</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 14 1982</b>             |   |  |
|  |  |   |  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Russ</b>  |  |   |   |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 4 0 4

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|  |  |  |   |   |  |   |   |  |  |
|--|--|--|---|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>VINCENT RAMAN</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JANUARY 26, 1982</b>                      |   |  | 2b. HOUR<br><b>1:40A M</b>  |   |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 12 15</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b>  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>YRS.</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                       |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Shop Planner</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. Coast Guard</b>   |  |
| 13a. STATE<br><b>Maryland</b>  |  |  | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Catonsville</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 13e. STREET ADDRESS<br><b>130 N. Symington Avenue 21228</b>  |  |  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Ramanauskas</b>                   |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anna Unknown</b>                    |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>   |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WW II 209-07-2584</b> |   | 17. INFORMANT<br>ADDRESS<br><b>Magdalen E. Raman 130 N. Symington Avenue 21228</b> |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Gastro intestinal bleeding</b><br>2030<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Thrombocytopenia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Multiple Myeloma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 days</b><br><b>1 month</b><br><b>1 year</b> |  |  |   |   |  |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>Invasive Candidiasis; Renal failure</b>  |  |  |   |   |  |   |   |  |  |
| 19a. DATE OF OPERATION<br><b>-</b>   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>-</b>                        |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>    |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                   |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)           |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)              |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                       |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 4, 1982</b> , to <b>Jan 26, 1982</b> , that (I) (we) last saw the deceased alive on <b>Jan 26, 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.   |  |  |   |   |  |   |   |  |  |
| 22b. SIGNATURE<br><b>BIB Bolger MD</b>   |  |  |   |   |  | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>Jan 26/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BOLGER, Graeme</b>   |  |  |   |   |  | 22e. ADDRESS<br><b>Johns Hopkins Hospital<br/>600 N Wolfe Street, Baltimore Md</b>      |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>1/29/82</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lake View Cemetery</b>                    |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Sykesville Carroll Md.</b>                     |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229</b>  |  |  |   |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 27 1982</b>                                     |   | 25b. REGISTRAR'S SIGNATURE<br><b>Frances Jan Nathan</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral home, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. **IMPORTANT:** If item 21 is marked unknown, it shows any injury, or other traumatic event, the medical examiner must be notified at once.



Item #76 Film G564 2/10/82 rc

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

8 2 0 1 4 0 5

FOR  
1. STATE  
REGISTRAR

## CERTIFICATE OF DEATH

REG. NO.

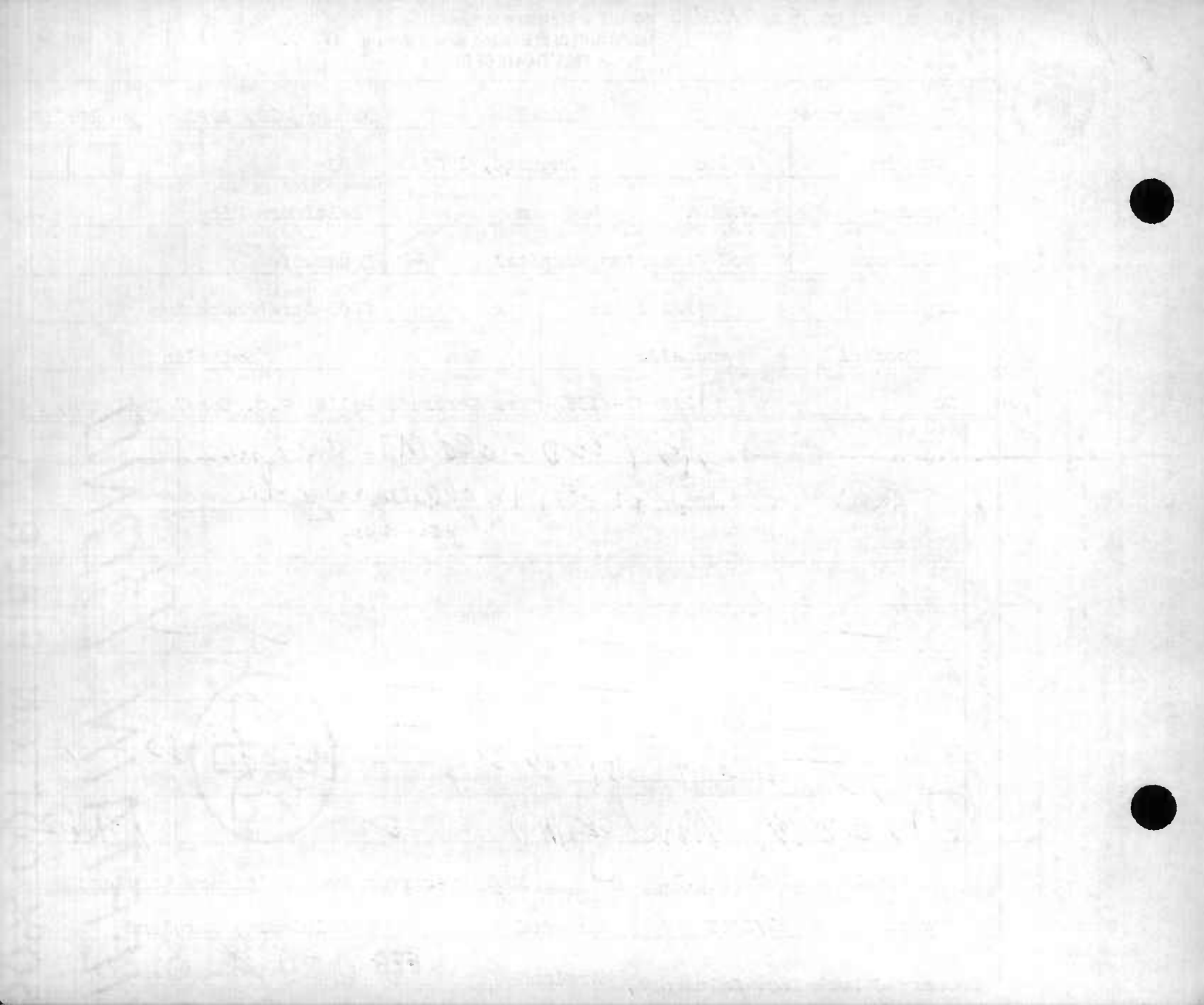
|  |   |   |   |  |   |
|--|---|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Margaret C Rassek</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 29, 1982</b>                                  |  | 2b. HOUR<br><b>10:15 PM</b>   |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>August 4, 1908</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b> YRS                                     | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Germany</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                    |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Good Samaritan Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |   |   |   |  |   |
| 13a. STATE<br><b>Maryland</b>  | 13b. COUNTY   | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>2609 Strathmore Ave</b>                                    |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Teofiel Muchalla</b>  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ann Smikalla</b>                            |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>218-42-4138</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Mrs Gertrude Palik P.O. Box 7 Fallston, Md</b>        |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>4148 AS A RD - old MI - angina</b><br>IMMEDIATE CAUSE (a) }<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Diabetes mellitus insulin dependent</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) }<br>CONDITIONS, IF ANY, WHICH<br>GAVE RISE TO IMMEDIATE<br>CAUSE (a), STATING THE<br>UNDERLYING CAUSE LAST. |   |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:10  |   |   |   |  |   |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/26/81</b> 19 to <b>Jan 29</b> 19 <b>82</b> , that (I) (we) lost<br>saw the deceased alive on <b>Dec 7</b> 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |   |   |   |  |   |
| 22b. SIGNATURE<br><b>Donald W. Mintzer M.D.</b>  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |   | 22c. DATE SIGNED<br><b>1/31/82</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Donald W Mintzer M.D.</b>  |   | 22e. ADDRESS<br><b>3009 Evergreen Ave Baltimore Maryland</b>  |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  | 23b. DATE<br><b>2/2/82</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>             |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J Ruck Inc. Baltimore, Maryland</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 1 1982</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>James J. North</b>                                  |   |

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                      |   |  |  |                             |  |  |  |  | REG. NO. 2 0 1 4 0 6                         |  |
|--|----------------------|---|--|--|-----------------------------|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Anthony L. Reddick</b>  |                      |   |  |  |                             | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> <b>1 1 1982</b> |  | 2b. HOUR <b>M</b>  |  |  |  |
| 3. SEX <b>male</b>   | 4. RACE <b>black</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>2 17 60</b>   | 6. AGE (IN YEARS LAST BIRTHDAY) <b>21 YRS.</b> | IF UNDER 1 YR. MONTHS DAYS   | IF UNDER 24 HRS. HOURS MIN. | 2c. DATE PRONOUNCED DEAD <b>1 1 1982</b>   |  | 2d. HOUR <b>3:12A</b>  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md</b>  |                      | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                             | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |                      | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1121 N. Gay Street</b> |  |  |                             | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| 13a. STATE <b>Md</b>   |                      | 13b. COUNTY   |  | 13c. CITY OR TOWN <b>Baltimore</b>   |                             | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                   |  | 13e. STREET ADDRESS <b>1603 N. Ensor Street</b>                                  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>Oscar J. Wingfield</b>   |                      |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Virginia Reddick</b>  |                             |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>   |                      | 16b. SOCIAL SECURITY NO. <b>N/A</b>   |  | 17. INFORMANT ADDRESS <b>Oscar Wingfield 1325 Central Ave</b>  |                             |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Gunshot wound of head</b> Weapon: <b>Unspecified</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |                      |   |  |  |                             |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |                      |   |  |  |                             |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |                      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |                             |  |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                      | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR <b>3:00AM 1/1 1982</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>subject shot</b>  |                             |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |                      | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>disco</b>  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE <b>1121 N. Gay Street, Baltimore, MD</b>   |                             |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                      |   |  |  |                             |  |  |  |  |  |  |
| ACTUAL SIGNATURE <b>H. R. Shaw</b>   |                      | M.D. <b>Assistant</b>   |  | MEDICAL EXAMINER   |                             |  |  | DATE SIGNED <b>1/1/82</b>  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Hormez R. Guard, MD</b>   |                      | ADDRESS <b>111 Penn Street, Balto. MD 21201</b>   |  |  |                             |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |                      | 23b. DATE <b>1/7/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>King Mem Park</b>  |                             | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>Balto Co. Md</b>   |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS <b>William C. March F/H 1101 E. North Ave</b>   |                      | 25a. DATE REC'D. BY REGISTRAR <b>JAN 5 1982</b>   |  | 25b. REGISTRAR SIGNATURE <b>Frances J. Nathan</b>  |                             |  |  |  |  |  |  |

RECEIVED

W. H. H. H.

MADE IN U.S.A.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 4 0 7

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |   |   |   |  |   |  |  |  |  |
|--|--|--|---|---|---|--|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>SAMUEL REESE</b>  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>Jan 17, 82</b>                                       |   |   | 2b. HOUR<br><b>4:30 P.M.</b>   |   |  |  |  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>MAR. 5, 1917</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>65 yrs.</b>  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>65 yrs.</b>   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>TEXAS</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>CITY</b> MD.  |   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSPITAL, BALTO.</b> |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>US. GOV'T.</b>  |   | 12b. POSITION, BUSINESS OR INDUSTRY CLASSIFIER   |  |  |  |
| 13a. STATE<br><b>MARYLAND</b>  |  |  | 13b. COUNTY   |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                         |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>4613 PARK HTS. AVE. 21215</b>      |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>SAUL Z. REESE</b>   |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>GERTRUDE DIAMOND</b>  |   |  |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>   |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WWII-AIRFORCE 444-03-6133</b> |   | 17. INFORMANT<br><b>HEBREW BURIAL &amp; SOC. SOCIETY</b>      |  |   |  | 17. ADDRESS<br><b>1330 REISTERSTOWN RD. BALTO., MD 21208</b> |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>0389 SEPTICEMIA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>/</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>/</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 days</b> |  |  |   |   |   |  |   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:<br><b>HYPOTHYROIDISM, PARKINSONISM, ATHEROSCLEROTIC HEART DISEASE</b>   |  |  |   |   |   |  |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>NIL 19</b>                       |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>NIL</b>   |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> <b>NIL</b>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>NIL</b>        |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/15/82</b> to <b>1/17/82</b> , that (I) (we) lost saw the deceased alive on <b>1/17/82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |   |   |   |  |   |  |  |  |  |
| 22b. SIGNATURE<br><b>Dr. A. Karim</b>  |  |  | DEGREE<br><b>MD</b>   |   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>1/17/82</b>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. A. KARIM</b>   |  |  | 22e. ADDRESS<br><b>Sinai Hospital, Baltimore MD.</b>  |   |   |  |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>BURIAL</b>   |  |  | 23b. DATE<br><b>JAN. 19, 1982</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE HEBREW</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b>                         |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>SOL LEVINSON &amp; BROS., INC.<br/>6010 REISTERSTOWN RD. BALTO., MD 21215</b>   |  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 20 1982</b>           |  |   |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Frances Jan. Nathan</b> |  |

1985 03 WA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |                    |   | REG. NO.  |   |
|--|--|---|--------------------|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>FRED</b>  |  |   | FIRST <b>REHNS</b> |   | 2a. DATE OF DEATH MONTH <b>1</b> DAY <b>29</b> YEAR <b>82</b> |   |
| 3. SEX <b>MALE</b>   |  | 4. RACE <b>WHITE</b>  |                    | 5. DATE OF BIRTH MONTH <b>12</b> DAY <b>09</b> YEAR <b>05</b>   |   | 2b. HOUR <b>5:30 PM</b>   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>GERMANY</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |                    | 6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.  |   | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.   |
| 10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SINAI</b> |                    | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>CITY BALTIMORE</b> MD   |   | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. STATE <b>MD</b>   |  | 13b. COUNTY <b>BALTIMORE</b>  |                    | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SELF EMPLOYED</b>                    |   | 12b. KIND OF BUSINESS OR INDUSTRY <b>METALLURGIST</b>   |
| 14. FATHER'S NAME FIRST <b>Moritz</b> MIDDLE LAST <b>Rindkopf</b>  |  | 15. MOTHER'S MAIDEN NAME FIRST <b>HANNAH</b> MIDDLE LAST <b>SCHIFF</b>  |                    | 13c. STREET ADDRESS <b>APT. 1A #21215</b>   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>  |  | 16b. SOCIAL SECURITY NO. <b>135-09-3316</b>   |                    | 17. INFORMANT <b>MRS. RUTH REHNS</b> ADDRESS <b>3516 LABYRINTH RD., APT. 1A #21215</b>                |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cardiogenic shock?</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Torsade de pointes, PE, AK+</b> |  |   |                    |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE FORMAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Probable anoxic encephalopathy; shock myelin.</b>  |  |   |                    |   |   |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                    | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                     |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                        |   |   |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |                    | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/29</b> , 19 <b>82</b> , to <b>1/29</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>1/29</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |                    |   |   |   |
| 22b. SIGNATURE <b>Alan M. Ringel</b>   |  | DEGREE <b>MD</b>  |                    | 22c. DATE SIGNED <b>1/29/82</b>   |   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ALAN M. RINGEL</b>  |  | 22e. ADDRESS <b>2523 STEELE RD.</b>   |                    |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>  |  | 23b. DATE <b>1-29-82</b>  |                    | 23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE HEBREW CONG. REISTERSTOWN BALTO.</b>                  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE   |
| 24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., INC.</b> ADDRESS <b>6010 REISTERSTOWN RD., BALTO., MD 21215</b>  |  |   |                    | 25a. DATE REC'D. BY REGISTRAR <b>FEB 2 1982</b> 25b. REGISTRAR'S SIGNATURE <b>Frances Jean Nathan</b> |   |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

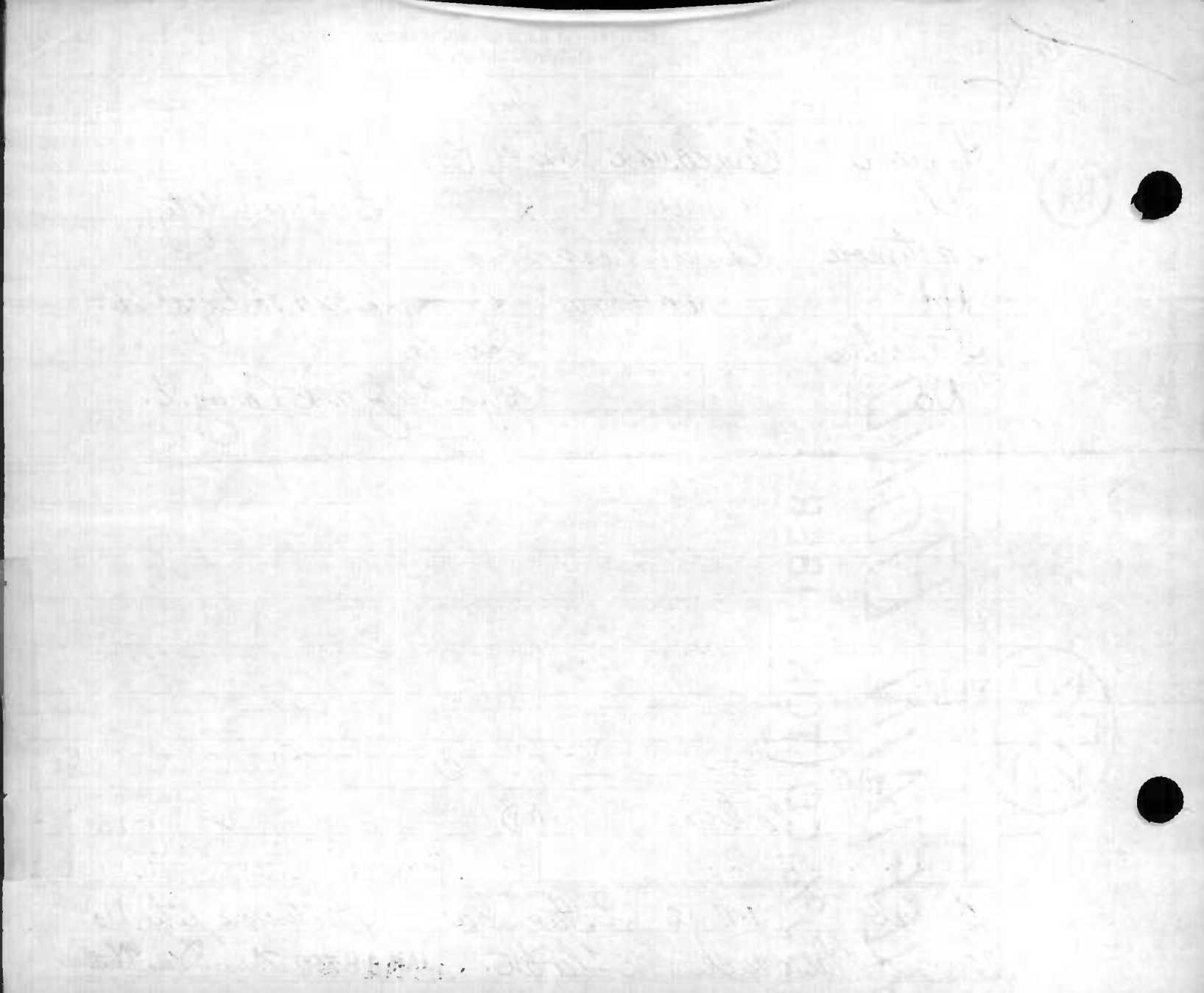
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO.   |  |
|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>HELEN</b>   |  | FIRST<br><b>REITZ</b>   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>01-13-82</b>                         |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Caucasian</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Jan 31, 1900</b>                      |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b>  |  | 7. GENDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>YES</b>  |  | 8. UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN.<br><b>YES</b>                       |  |
| 9. BIRTHPLACE (STATE OR FOREIGN)<br><b>MD.</b>  |  | 10. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 11. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>                 |  |
| 12. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br><b>Church Hosp Inc</b> |  | 14. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING CARE)<br><b></b>     |  |
| 15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>15a. STATE<br><b>MD</b>  |  | 15b. COUNTY<br><b>Baltimore</b>   |  | 15c. CITY OR TOWN<br><b>Baltimore</b>  |  |
| 16. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Stanislaus</b>   |  | 17. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Sophia</b>  |  | 18. STREET ADDRESS<br><b>2024 Portugal St.</b>                                 |  |
| 19. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES OR UNRECORDED)<br><b>No</b>   |  | 20. SOCIAL SECURITY NO.<br><b></b>  |  | 21. INFORMANT<br>ADDRESS<br><b>Joseph Reitz 7245 Conley St.</b>                |  |
| 22. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b><br>1629<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>LUNG CANCER</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b><br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>01-13-82</b> , to <b>01-13-82</b> , that (I) (we) lost saw the deceased alive on <b>01-13-82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>E.V. Platia</b>  |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>1-13-82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. E. V. PLATIA M.D.</b>   |  | 22e. ADDRESS<br><b>CHURCH HOSPITAL CORPORATION<br/>100 N. BROADWAY, BALTIMORE, MARYLAND 21231</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE)<br><b>Burial</b>  |  | 23b. DATE<br><b>1-18-82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Stanislaus</b>                    |  |
| 23d. LOCATION<br>(CITY OR TOWN)<br><b>Baltimore City, Md.</b>   |  | 23e. STATE<br><b>MD.</b>  |  | 23f. DATE REC'D. BY REGISTRAR<br><b>JAN 18 1982</b>                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Raymond J. Kozowski</b>  |  | 24b. ADDRESS<br><b>255 Hill St.</b>   |  | 24c. REGISTRAR'S SIGNATURE<br><b>James Van Natta</b>                           |  |



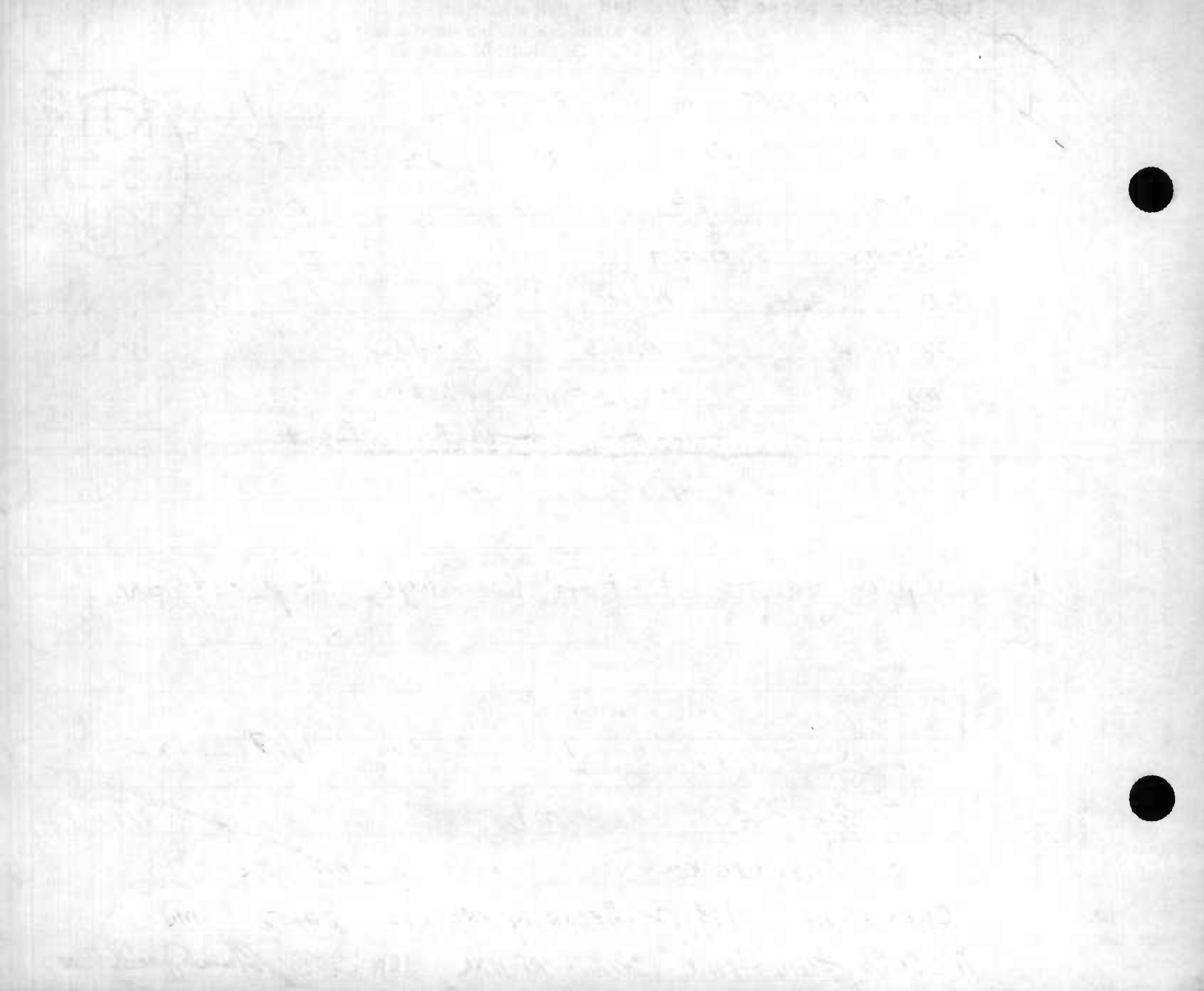


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director. Page 3 should be retained by the funeral director. Page 4 should be retained by the funeral director. Page 5 should be retained by the funeral director. Page 6 should be retained by the funeral director. Page 7 should be retained by the funeral director. Page 8 should be retained by the funeral director. Page 9 should be retained by the funeral director. Page 10 should be retained by the funeral director. Page 11 should be retained by the funeral director. Page 12 should be retained by the funeral director. Page 13 should be retained by the funeral director. Page 14 should be retained by the funeral director. Page 15 should be retained by the funeral director. 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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |   |  |
|---|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>MARGARET M. REJRAT</b>   |  |   |  |   |  |  |  |   |  |
| 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR<br><b>1 17 82 840 A.M.</b>  |  |   |  |   |  |  |  |   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>W</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>10 2 23</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br><b>58</b>  |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>PA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balt. City</b> MD.  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>S.B.G.H.</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>-</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>-</b>   |  |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>Balt.</b>   |  | 13c. CITY OR TOWN<br><b>Balt</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>4202 Morrison Ct 21226</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>William DAVIS</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Matilda Webber</b>   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>204-12-5581</b>  |  | 17. INFORMANT<br><b>B. Hallick M.D.</b>   |  | ADDRESS<br><b>3001 S. Hanover St.</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute myocardial infarct</b><br><b>4100</b><br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST<br>(b) <b>Atherosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)         |  |   |  |   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Upper gas fro intestinal hemorrhage, Aspiration</b>  |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION<br><b>1/17</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Aspiration</b>   |  |   |  | 20a. AUTOPSY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.<br><b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)  |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/17</b> 19 <b>82</b> to <b>1/17</b> 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>1/17</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.) |  |   |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>B. Hallick</b>   |  |   |  | DEGREE<br><b>MD</b>   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1/17/82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>G. HALLICK</b>  |  |   |  | 22e. ADDRESS<br><b>3001 S. HANOVER ST.</b>  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>CREMATION</b>   |  | 23b. DATE<br><b>1/19/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>SECURITY PROCESS</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>BALTO. MD.</b>   |  |   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>McCull, Fun. Home</b>   |  |   |  | ADDRESS<br><b>130 E. FORT AVE</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 19 1982</b>  |  | REGISTRAR'S SIGNATURE<br><b>Thom J. [Signature]</b>   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in this 72-hour death depth with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 4 1 1

|   |   |   |   |
|---|---|---|---|
| 1. FOR STATE REGISTRAR  |   | REG. NO.  |   |
| 1. DECEASED NAME (TYPE OR PRINT)  |   | 2a. DATE OF DEATH   |   |
| FIRST MIDDLE LAST<br>Gordon M Rever   |   | MONTH DAY YEAR HOUR<br>1 9 82 10: A M   |   |
| 3 SEX   | 4 RACE  | 5. DATE OF BIRTH  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |
| Male  | Caucasian   | MONTH DAY YEAR<br>7 24 18   | 63 YRS  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b CITIZEN OF WHAT COUNTRY?   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH                                 |
| Maryland  | United States   |   | Baltimore City MD   |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |
| Baltimore, Md   | Mercy Hospital, Baltimore, Md.  | Retired   |   |
| 13a STATE   | 13b COUNTY  | 13c CITY OR TOWN  | 13d INSIDE CITY LIMITS?   |
| Md.   |   | Baltimore City  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14 FATHER'S NAME  | 15. MOTHER'S MAIDEN NAME  | 13e STREET ADDRESS  |   |
| FIRST MIDDLE LAST<br>Ferdinand  | FIRST MIDDLE LAST<br>Edith Gill   | 5929 Cedonia Avenue 21206   |   |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  | 16b SOCIAL SECURITY NO.   | 17 INFORMANT ADDRESS  |   |
| Yes   | Army WWII   | Mrs. Irene J. Rever - 5929 Cedonia Ave. - 21206   |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |
| IMMEDIATE CAUSE (a) 4100 Cardiac Arrest   |   |   |   |
| DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial Infarction  |   |   | 4 Days  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |   |   |   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a  |   |   |   |
| 19a DATE OF OPERATION   | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a AUTOPSY?  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |
|   |   | YES <input type="checkbox"/> NO <input type="checkbox"/>  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B. PART I OR PART 2)   |   |
|   |   |   |   |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f LOCATION STREET CITY OR TOWN COUNTY STATE   |   |
|   |   |   |   |
| 22a I certify that (I) (this hospital) attended the deceased from 1/9 82 to 1/9 82, that (I) (we) last saw the deceased alive on 1/9 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (not) view the body after death. |   |   |   |
| 22b SIGNATURE   | DEGREE  | 22c DATE SIGNED   |   |
| Neal M. Friedlander, MD   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 1/9/82  |   |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)  | 22e ADDRESS   |   |   |
| Neal M. Friedlander, MD   | 301 St. Paul St Baltimore, Md 21202   |   |   |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)  | 23b DATE  | 23c NAME OF CEMETERY OR CREMATORY   | 23d LOCATION  |
| Burial  | 1-12-82   | Gardens of Faith Cem.   | Balto. Md.  |
| 24 FUNERAL DIRECTOR   | 25a DATE REC'D. BY REGISTRAR  | 25b REGISTRAR SIGNATURE   |   |
| John C. Miller Inc-6415 Belair Rd.-21206  | JAN 12 1982   | James J. P. P.  |   |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |   |  |  |   |                                    |  |                                      | 8  | 2 | 0  | 1 | 4  | 1                      | 2                   |  |          |  |
|--|--|--|---|--|--|---|------------------------------------|--|--------------------------------------|--|---|--|---|--|------------------------|---------------------|--|----------|--|
| 1- FOR STATE REGISTRAR   |  |  |   |  |  |   |                                    |  |                                      | CERTIFICATE OF DEATH   |   |  |   |  |                        |                     |  |          |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  |   |  |  |   |                                    |  |                                      | 2a. DATE OF DEATH  |   | MONTH  |   | DAY  |                        | YEAR                |  | 2b. HOUR |  |
| LUTHER REYNOLDS  |  |  |   |  |  |   |                                    |  |                                      | 1-7-82   |   | XXXXXX   |   |  |                        |                     |  | 5:30p M  |  |
| 3. SEX   |  |  | 4. RACE   |  |  | 5. DATE OF BIRTH  |                                    |  | 6. AGE (IN YEARS LAST BIRTHDAY)      |  |   | IF UNDER 1 YEAR  |   |  | IF UNDER 24 HRS        |                     |  |          |  |
| Male   |  |  | White   |  |  | 4-21-24   |                                    |  | 57                                   |  |   | YRS.   |   |  | MONTHS DAYS HOURS MIN. |                     |  |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |   |  |   |  |                        |                     |  |          |  |
| Virginia   |  |  | USA   |  |  |   |                                    |  | Baltimore CITY MD.                   |  |   |  |   |  |                        |                     |  |          |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |   |                                    |  |                                      |  |   |  |   |  |                        |                     |  |          |  |
| Baltimore  |  |  | 1159 Cleveland Street   |  |  |   |                                    |  |                                      |  |   |  |   |  |                        |                     |  |          |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |   |                                    |  |                                      |  |   |  |   |  |                        |                     |  |          |  |
| Machine Operator   |  |  | Sugar Ind.  |  |  |   |                                    |  |                                      |  |   |  |   |  |                        |                     |  |          |  |
| 13a. STATE   |  |  |   |  |  |   |                                    |  |                                      | 13b. COUNTY  |   | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS?                                 |                        | 13e. STREET ADDRESS |  |          |  |
| Md.  |  |  |   |  |  |   |                                    |  |                                      | Balt.  |   | Baltimore  |   | YES <input type="checkbox"/> NO <input type="checkbox"/> |                        | 1159 Cleveland St.  |  |          |  |
| 14. FATHER'S NAME  |  |  |   |  | 15. MOTHER'S MAIDEN NAME   |   |                                    |  |                                      |  |   |  |   |  |                        |                     |  |          |  |
| Isaac Reynolds   |  |  |   |  | Lottie Irvin   |   |                                    |  |                                      |  |   |  |   |  |                        |                     |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |  |   |  | 16b. SOCIAL SECURITY NO.   |   |                                    |  |                                      | 17. INFORMANT ADDRESS  |   |  |   |  |                        |                     |  |          |  |
| Yes  |  |  |   |  | W.W. II  |   |                                    |  |                                      | 228-12-3739 Charlotte Reynolds (spouse) Same as #13  |   |  |   |  |                        |                     |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory failure</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic Carcinoma to Trachea</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>From Squamous Cell Carcinoma of Base of Tongue</u>                              |  |  |   |  |  |   |                                    |  |                                      |  |   |  |   |  |                        |                     |  |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |   |  |  |   |                                    |  |                                      |  |   |  |   |  |                        |                     |  |          |  |
| 19a. DATE OF OPERATION   |  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |                                    |  |                                      | 20a. AUTOPSY?  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |   |  |                        |                     |  |          |  |
| 1/4/82   |  |  |   |  | Tracheostomy   |   |                                    |  |                                      | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |   |  |                        |                     |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |                                    |  |                                      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |   |  |                        |                     |  |          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |                                    |  |                                      | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |   |  |                        |                     |  |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Dec.</u> 19 <u>81</u> , to <u>Jan. 6</u> 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>1/6/82</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |  |  |   |                                    |  |                                      |  |   |  |   |  |                        |                     |  |          |  |
| 22b. SIGNATURE <u>G. S. Elias, M.D.</u>  |  |  |   |  |  |   |                                    |  |                                      | DEGREE   |   | 22c. DATE SIGNED   |   |  |                        |                     |  |          |  |
|  |  |  |   |  |  |   |                                    |  |                                      | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 1/8/82   |   |  |                        |                     |  |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |   |  |  |   |                                    |  |                                      | 22e. ADDRESS   |   |  |   |  |                        |                     |  |          |  |
| George Elias, M.D.   |  |  |   |  |  |   |                                    |  |                                      | University Hospital, Baltimore, Md.  |   |  |   |  |                        |                     |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  |  |   |  | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY |  |                                      |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                     |   |  |                        |                     |  |          |  |
| Removal  |  |  |   |  | 1-7-82   |   |                                    |  |                                      |  |   |  |   |  |                        |                     |  |          |  |
| 24. FUNERAL DIRECTOR<br>NAME   |  |  |   |  |  |   |                                    |  |                                      | ADDRESS  |   | 25a. DATE REC'D. BY REGISTRAR                                  |   | 25b. REGISTRAR'S SIGNATURE                               |                        |                     |  |          |  |
| Anatomy Board of Md. Baltimore, Maryland   |  |  |   |  |  |   |                                    |  |                                      |  |   | JAN 14 1982  |   |  |                        |                     |  |          |  |

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University Hospital, Baltimore, Md.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

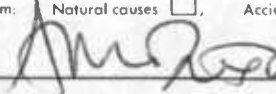

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

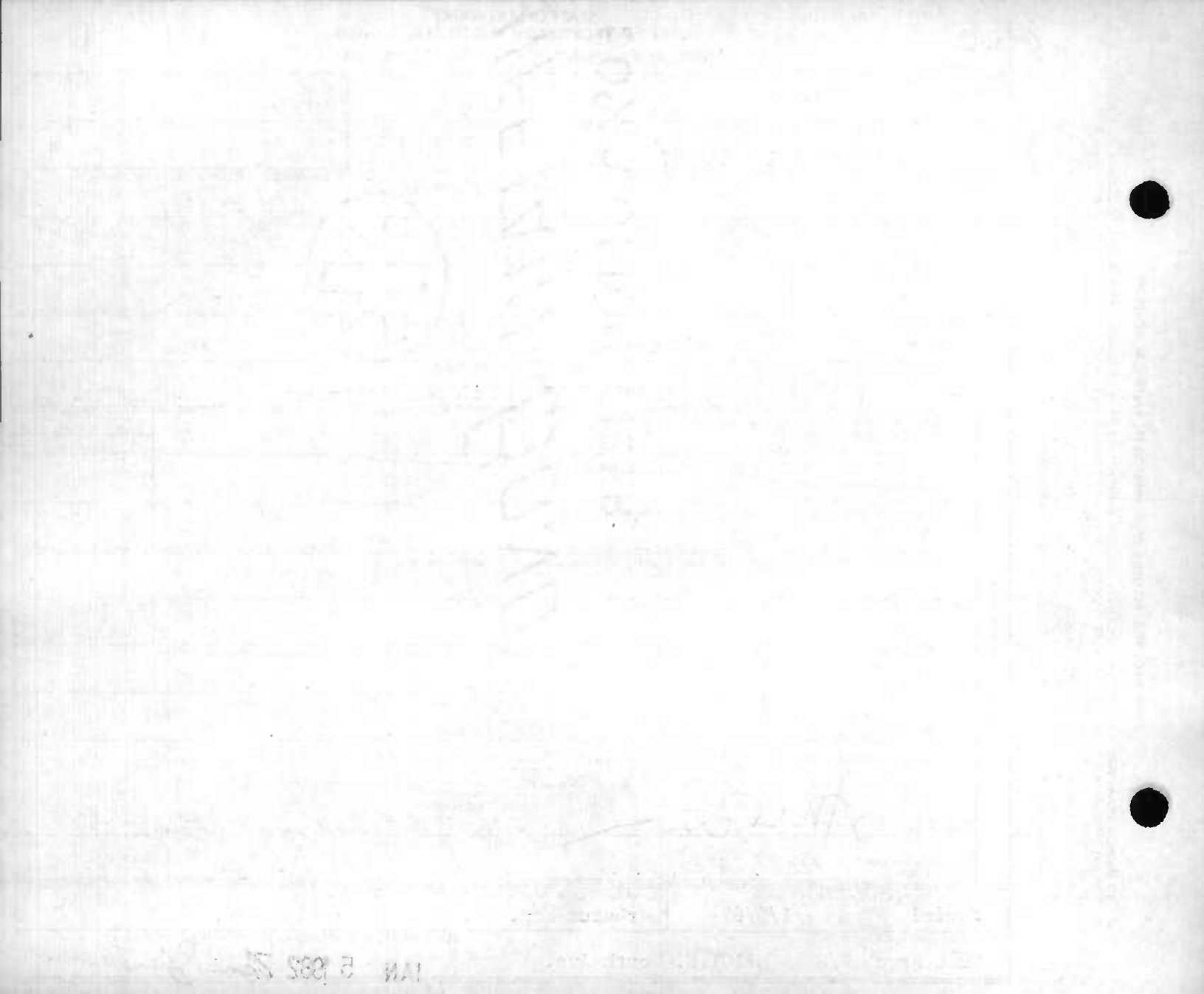
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |   |  |   |  |   |  | 8 2 0 1 4 1 3  |  |
|---|--|--|--|---|--|---|--|---|--|--|--|
| 1- FOR STATE REGISTRAR  |  |  |  |   |  |   |  |   |  | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Charles E. Rice Sr.</b>  |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH <b>1</b> DAY <b>16</b> YEAR <b>1982</b>  |  | 2b. HOUR<br><b>3:45 P.</b> M.   |  |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>3</b> DAY <b>31</b> YEAR <b>1897</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>                                    |  | IF UNDER 24 HRS.<br>HOURS <b></b> MIN. <b></b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NO HOSPITAL, GIVE HOME ADDRESS)<br><b>3900 N. Charles St.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ch. of Board</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Mechanical</b>                            |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |   |  |   |  |   |  |  |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>3900 N. Charles St.</b>                                 |  |  |  |
| 14. FATHER'S NAME<br>FIRST <b>Wm</b> MIDDLE <b>I</b> LAST <b>Rice</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Margaret</b> MIDDLE <b>unknown</b> LAST <b></b>  |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   |  | 17. INFORMANT ADDRESS<br><b>Charles E. Rice Jr 7715 Ruxwood Rd.</b>   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>STROKE</b><br>1850<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>PNEUMONITIS</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>CARCINOMATOSIS, PROSTATIC</b> |  |  |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 day</b><br><b>1 day</b><br><b>4 YEARS</b>                             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>OSTEOARTHRITIS HIPS AND SPINE</b>   |  |  |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>         |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) <u>the hospital</u> attended the deceased from <b>FEB 2 19 72</b> to <b>JAN 16 19 82</b> , that (I) <u>did not</u> view the deceased alive on <b>JAN 16 19 82</b> , and that in (my) <u>best</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>did not</u> view the body after death.  |  |  |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Wm Carl Ebeling MD</b>   |  |  |  |   |  | DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |  | 22c. DATE SIGNED<br><b>1-18-82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>William C. Ebeling M.D.</b>   |  |  |  |   |  | 22e. ADDRESS<br><b>7401 Osler Dr.</b>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |  |  | 23b. DATE<br><b>1/19/1982</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN <b>Woodlawn</b> COUNTY <b>Balto</b> STATE <b>Md</b> |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Mitchell-Wiedefeld Home</b> ADDRESS <b>6500 York Rd.</b>  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 18 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Thomas J. Nathan</b>                             |  |  |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| FOR STATE REGISTRAR  |  |                      |  |   |  |  |  |                            |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |  |  |  |  |  |  | MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                          |  |  |  |  |  |  |  | REG. NO. 8 2 0 1 4 1 4   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|--|--|----------------------|--|---|--|--|--|----------------------------|--|---|--|--|--|--|--|--|--|--|--|--|--|--------------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>CLIFTON G. RICHARDSON</b>   |  |                      |  |   |  |  |  |                            |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR <b>1 1 1982</b>  |  |  |  |  |  |  |  |  |  | 2b. HOUR <b>M</b>  |  |                          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 3. SEX <b>male</b>   |  | 4. RACE <b>negro</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>1 11 47</b> |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>34 YRS.</b> |  | IF UNDER 1 YR. MONTHS DAYS |  | IF UNDER 24 HRS. HOURS MIN.   |  | 7c. DATE PRONOUNCED DEAD <b>1 1 1982</b> |  |  |  |  |  |  |  |  |  | 7d. HOUR <b>7:05 P M</b> |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>   |  |                      |  |   |  |  |  |                            |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  |  |  |  |  |  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                          |  |  |  |  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.                               |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |  |                      |  |   |  |  |  |                            |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Johns Hopkins Hospital</b> |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |                          |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 13a. STATE <b>Md.</b>  |  |                      |  |   |  |  |  |                            |  | 13b. COUNTY   |  |  |  |  |  |  |  |  |  | 13c. CITY OR TOWN <b>Balto.</b>  |  |                          |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |  |  |  |  |  |  |  |  | 13e. STREET ADDRESS <b>1537 N. Ensor St.</b> |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>Eugene Richardson</b>  |  |                      |  |   |  |  |  |                            |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Mildred James</b>  |  |  |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>   |  |                      |  |   |  |  |  |                            |  | 16b. SOCIAL SECURITY NO. <b>215-52-3017</b>   |  |  |  |  |  |  |  |  |  | 17. INFORMANT <b>Mildred Richardson</b>  |  |                          |  |  |  |  |  |  |  | ADDRESS <b>253 Douglass Ct.</b>  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Stab wound of abdomen</b><br><b>9660</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF |  |                      |  |   |  |  |  |                            |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                      |  |   |  |  |  |                            |  |   |  |  |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |                      |  |   |  |  |  |                            |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |  |  |  |  |  |  | 20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |                          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                      |  |   |  |  |  |                            |  | 21b. TIME OF INJURY<br>HOUR <b>5:45</b> MONTH <b>1</b> DAY <b>1</b> YEAR <b>1982</b>  |  |  |  |  |  |  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2) <b>Subject was stabbed.</b>  |  |                          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK  |  |                      |  |   |  |  |  |                            |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>home</b>   |  |  |  |  |  |  |  |  |  | 21f. LOCATION<br>STREET <b>1537 Ensor St.</b> CITY OR TOWN <b>Balto.</b> COUNTY STATE <b>Md.</b>   |  |                          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>  |  |                      |  |   |  |  |  |                            |  | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion    |  |  |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE    |  |                      |  |   |  |  |  |                            |  | TITLE (SPECIFY) <b>Assistant</b> M.D. MEDICAL EXAMINER  |  |  |  |  |  |  |  |  |  | DATE SIGNED <b>1-2-82</b>  |  |                          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>  |  |                      |  |   |  |  |  |                            |  | ADDRESS <b>111 Penn St.</b>   |  |  |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  |                      |  |   |  |  |  |                            |  | 23b. DATE <b>1/8/82</b>   |  |  |  |  |  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Mem. Pk.</b>   |  |                          |  |  |  |  |  |  |  | 23d. LOCATION<br>CITY OR TOWN <b>Arbutus, Md.</b> COUNTY STATE                               |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Wm C March F/H</b> ADDRESS <b>1101 E. North Ave.</b>   |  |                      |  |   |  |  |  |                            |  | 25a. DATE REC'D. BY REGISTRAR <b>JAN 5 1982</b>   |  |  |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE    |  |                          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |         |  |   |  |                   |  |  |  |                  |  |                                      |  |  |  |                     |  |   |  |
|---|--|---------|--|---|--|-------------------|--|--|--|------------------|--|--------------------------------------|--|--|--|---------------------|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |         |  | FIRST MIDDLE LAST   |  |                   |  | 2a. DATE KNOWN OF DEATH  |  |                  |  | XX MONTH DAY YEAR                    |  |  |  | 7b. HOUR            |  |   |  |
| Mary  |  |         |  | L. Richardson   |  |                   |  | 13 19 82   |  |                  |  |                                      |  |  |  | M                   |  |   |  |
| 3. SEX  |  | 4. RACE |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS) |  | IF UNDER 1 YR.   |  | IF UNDER 24 HRS. |  | 7c. DATE PRONOUNCED DEAD             |  |  |  | 7d. HOUR            |  |   |  |
| Female  |  | Black   |  | 9 30 22   |  | 59 YRS.           |  |  |  |                  |  | 1 13 19 82                           |  |  |  | P. M.               |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |         |  | 7b. CITIZEN OF WHAT COUNTRY?                                |  |                   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |  |  |                     |  |   |  |
| Va.   |  |         |  | U.S.A   |  |                   |  |  |  |                  |  | Baltimore City,                      |  |  |  | MD.                 |  |   |  |
| 10. CITY OR TOWN OF DEATH   |  |         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION    |  |                   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |                  |  | 12b. KIND OF BUSINESS OR INDUSTRY    |  |  |  |                     |  |   |  |
| Baltimore   |  |         |  | Johns Hopkins Hospital-DOA                                  |  |                   |  | maintenance  |  |                  |  | Govt.                                |  |  |  |                     |  |   |  |
| 13a. STATE  |  |         |  | 13b. COUNTY   |  |                   |  | 13c. CITY OR TOWN  |  |                  |  | 13d. INSIDE CITY LIMITS?             |  |  |  | 13e. STREET ADDRESS |  |   |  |
| Md.   |  |         |  | Balto.  |  |                   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |                  |  | 813 McKim St.                        |  |  |  |                     |  |   |  |
| 14. OTHER NAME  |  |         |  | 15. MOTHER'S MAIDEN NAME                                    |  |                   |  |  |  |                  |  |                                      |  |  |  |                     |  |   |  |
| Russell   |  |         |  | Walker  |  |                   |  | Willie   |  |                  |  | Minor                                |  |  |  |                     |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  |  |         |  | 16b. SOCIAL SECURITY NO.                                    |  |                   |  | 17. INFORMANT  |  |                  |  | ADDRESS                              |  |  |  |                     |  |   |  |
| No  |  |         |  | 227-32-0223   |  |                   |  | Rosalee Heath  |  |                  |  | 813 McKim St.                        |  |  |  |                     |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |         |  |   |  |                   |  |  |  |                  |  |                                      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                     |  |   |  |
| PART I DEATH WAS CAUSED BY:   |  |         |  |   |  |                   |  |  |  |                  |  |                                      |  |  |  |                     |  |   |  |
| IMMEDIATE CAUSE (a). Arteriosclerotic Cardiovascular Disease  |  |         |  |   |  |                   |  |  |  |                  |  |                                      |  |  |  |                     |  |   |  |
| 4292  |  |         |  |   |  |                   |  |  |  |                  |  |                                      |  |  |  |                     |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |         |  |   |  |                   |  |  |  |                  |  |                                      |  |  |  |                     |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:   |  |         |  |   |  |                   |  |  |  |                  |  |                                      |  |  |  |                     |  |   |  |
| (b)   |  |         |  |   |  |                   |  |  |  |                  |  |                                      |  |  |  |                     |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |         |  |   |  |                   |  |  |  |                  |  |                                      |  |  |  |                     |  |   |  |
| (c)   |  |         |  |   |  |                   |  |  |  |                  |  |                                      |  |  |  |                     |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |         |  |   |  |                   |  |  |  |                  |  |                                      |  |  |  |                     |  |   |  |
| 19a. DATE OF OPERATION  |  |         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  |                   |  |  |  |                  |  |                                      |  |  |  |                     |  | 20. AUTOPSY?  |  |
|   |  |         |  |   |  |                   |  |  |  |                  |  |                                      |  |  |  |                     |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |         |  | 21b. TIME OF INJURY   |  |                   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |                  |  |                                      |  |  |  |                     |  |   |  |
|   |  |         |  | HOUR A.M. MONTH DAY YEAR                                    |  |                   |  |  |  |                  |  |                                      |  |  |  |                     |  |   |  |
|   |  |         |  | P.M. 19   |  |                   |  |  |  |                  |  |                                      |  |  |  |                     |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  |                   |  | 21f. LOCATION  |  |                  |  |                                      |  |  |  |                     |  |   |  |
|   |  |         |  |   |  |                   |  | STREET CITY OR TOWN COUNTY STATE   |  |                  |  |                                      |  |  |  |                     |  |   |  |
| 22. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |         |  |   |  |                   |  |  |  |                  |  |                                      |  |  |  |                     |  |   |  |
| ACTUAL SIGNATURE  |  |         |  | TITLE (SPECIFY)   |  |                   |  | DATE SIGNED  |  |                  |  |                                      |  |  |  |                     |  |   |  |
| Virginia L. Dolan   |  |         |  | M.D. Assistant  |  |                   |  | 1-14-82  |  |                  |  |                                      |  |  |  |                     |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |  |         |  | ADDRESS   |  |                   |  |  |  |                  |  |                                      |  |  |  |                     |  |   |  |
| Virginia L. Dolan, M.D.   |  |         |  | 111 Penn Street   |  |                   |  |  |  |                  |  |                                      |  |  |  |                     |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |         |  | 23b. DATE   |  |                   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |                  |  | 23d. LOCATION (CITY OR TOWN)         |  |  |  | COUNTY              |  |   |  |
| Burial  |  |         |  | 1-18-82   |  |                   |  | Balto. Nat'l Cem.  |  |                  |  | Balto.                               |  |  |  | Md.                 |  |   |  |
| 24. FUNERAL DIRECTOR NAME   |  |         |  | ADDRESS   |  |                   |  | 25a. DATE REC'D. BY REGISTRAR  |  |                  |  | 25b. REGISTRAR SIGNATURE             |  |  |  |                     |  |   |  |
| Carlton C. Douglass   |  |         |  | 1012 Penn Ave.  |  |                   |  | JAN 18 1982  |  |                  |  | James J. Nathan                      |  |  |  |                     |  |   |  |

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1911

1911

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |   |  |   |   |  |
|--|---|--|---|---|--|
| 1. FOR STATE REGISTRAR   |   | 2. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR  |   | 7b. HOUR  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |   | FIRST MIDDLE LAST  |   | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR                          |  |
| MILDRED  |   | RICHARDSON   |   | 1-21-82 19  |  |
| 3. SEX   | 4. RACE   | 5. DATE OF BIRTH MONTH DAY YEAR  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN         | 7c. DATE PRONOUNCED DEAD  | 7d. HOUR                                     |
| female   | black   | 7 7 30   | 51 YRS.   | 1-21-82 19  | 6:34A  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |
| MD   | U.S.A.  |  |   | Baltimore City MD.  |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |   | 12b. KIND OF BUSINESS OR INDUSTRY            |
| Baltimore  | University Hospital S.T.U.  |  |   |   |  |
| 13a. STATE   |   | 13b. COUNTY  | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>        | 13e. STREET ADDRESS                          |
| MD   |   | Baltimore  |   |   | 1100 Bolton St.                              |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |   |   |  |
| Charles Bland  |   | Susie ?  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |   | 16b. SOCIAL SECURITY NO.   | 17. INFORMANT ADDRESS   |   |  |
| No   |   | N/A  | Elliott Richardson 1248 Rossiter Ave.                         |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a)-(b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pelvic injuries</u><br>9570<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause last</u> .<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |   |  |   |   |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                    |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |   | 21b. TIME OF INJURY 3:30 PM MONTH DAY YEAR 19-82   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                       |  |
|  |   |  |   | subject jumped from window  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) apartment  |   | 21f. LOCATION (CITY OR TOWN, STREET, COUNTY, STATE) 1100 Bolton Street Apt. 307 Baltimore, Maryland |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |   |  |   |   |  |
| ACTUAL SIGNATURE <u>Margarita A. Koroll</u>  |   | TITLE (SPECIFY) Assistant  |   | DATE SIGNED 1-22-82   |  |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Koroll, M.D.  |   | ADDRESS 111 Penn Street  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  | 23b. DATE   | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION (CITY OR TOWN, COUNTY, STATE)   |  |
| Burial   | 1/26/82   | Baltimore Cemetery   |   | Baltimore MD  |  |
| 24. FUNERAL DIRECTOR NAME  |   | ADDRESS  |   | 25a. DATE REC'D. BY REGISTRAR   |  |
| Wm. C. March F/H, Inc.   |   | 1101 E. North Avenue   |   | JAN 25 1982   |  |
|  |   |  |   | 25b. REGISTRAR'S SIGNATURE <u>Thomas J. [Signature]</u>   |  |





Jan 22 1882

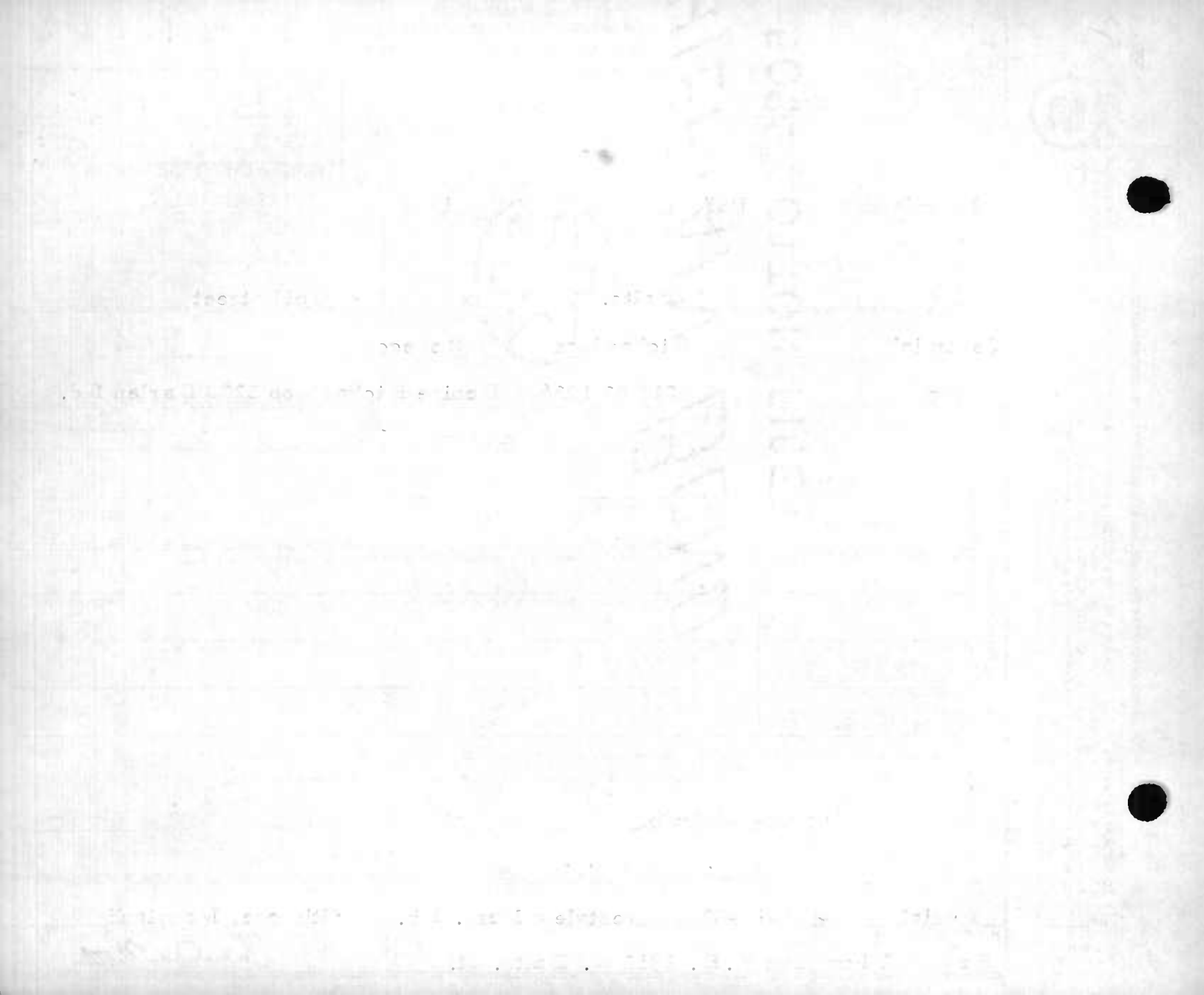
Jan 22 1882

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |  |
|---|--|---|--|--|
| 1- FOR<br>STATE<br>REGISTRAR  |  | 2a. DATE KNOWN<br>OF ESTI-<br>DEATH MATED <input checked="" type="checkbox"/> 1 13 1982   |  | 2b. HOUR<br>M 4:30<br>a. M   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Odessa Richardson  |  | 3. SEX<br>Female  |  | 4. RACE<br>Black   |
| 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 9 28  |  | 6. AGE (IN YEARS<br>LAST BIRTHDAY)<br>53 YRS.   |  | 7. CITIZEN OF WHAT COUNTRY?<br>USA   |
| 7c. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)<br>Maryland  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                              |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>548 Gold Street                               |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)                         |
| 13a. STATE<br>Md  |  | 13b. COUNTY<br>Balto.   |  | 13c. STREET ADDRESS<br>548 Gold Street   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Jeremiah Richardson   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Rebecca  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>215 52 1936  |  | 17. INFORMANT<br>Denise Richardson 5220 Darlen Rd.                                       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Left Subdural Hematoma</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a) stating the under-<br>lying cause last.   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><u>Cirrhosis of Liver</u>  |  |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>      |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>? P.M. ? ? 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>unknown |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC)<br>?  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>unknown                             |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion<br>death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |   |  |  |
| ACTUAL<br>SIGNATURE <u>Virginia L. Dolan</u>  |  | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER  |  | DATE<br>SIGNED 1-13-82   |
| EXAMINER'S NAME<br>(TYPE OR PRINT) Virginia L. Dolan, M.D.  |  | ADDRESS 111 Penn Street   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) Burial   |  | 23b. DATE<br>1-19-82  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview Mem. Pk.                                  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Brown / Thompson F.H.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 18 1982   |
| 25b. REGISTRAR'S SIGNATURE<br><u>James J. Norton</u>  |  |   |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medic

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 8 2 0 1 4 1 8   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1- FOR STATE REGISTRAR  |  |   |  | CERTIFICATE OF DEATH  |  |  |  |
| 1. DECEASED NAME  |  |   |  | 2a. DATE OF DEATH   |  |  |  |
| FIRST MIDDLE LAST   |  |   |  | MONTH DAY YEAR  |  |  |  |
| THOMAS A. RICHENS, Sr.  |  |   |  | JANUARY 15, 1982  |  |  |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE   |  |
| Male  |  | White   |  | MONTH DAY YEAR<br>May 27, 1895  |  | 86   |  |
| 7a. BIRTHPLACE  |  | 7b. CITIZEN OF WHAT COUNTRY?                            |  | 8. MARRIED  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |  |
| Avoca, Penn.  |  | U.S.A.  |  | NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | BALTIMORE CITY   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION |  | 12a. USUAL OCCUPATION   |  | 12b. INDUSTRY  |  |
| BALTIMORE   |  | MARYLAND GENERAL HOSPITAL                               |  | Pipe Fitter   |  | U.S. Coast Guard   |  |
| 13a. USUAL RESIDENCE  |  |   |  | 13b. INSIDE CITY LIMITS?  |  |  |  |
| 13a. STATE  |  |   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| Md.   |  |   |  | 1619 Rosedale Heights Ave.  |  |  |  |
| 14. FATHER'S NAME   |  |   |  | 15. MOTHER'S MAIDEN NAME  |  |  |  |
| FIRST MIDDLE LAST<br>Joseph Richens   |  |   |  | FIRST MIDDLE LAST<br>Margaret Morgan  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  |  |   |  | 17. INFORMANT   |  |  |  |
| YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> (IF YES, GIVE WAR OR DATES)   |  |   |  | Baltimore, Md. 21237.<br>Mrs. Bessie M. Richens-1619 Rosedale Heights Ave.  |  |  |  |
| 18. CAUSE OF DEATH  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |
| PART I. DEATH WAS CAUSED BY:  |  |   |  | 40 minutes  |  |  |  |
| IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION   |  |   |  |   |  |  |  |
| 4100  |  |   |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |   |  |  |  |
| (b) ATHEROSCLEROTIC HEART DISEASE   |  |   |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |   |  |  |  |
| (c)   |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |  |  |
| STATUS POST PREVIOUS MYOCARDIAL INFARCTION; ANEURYSM  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED        |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>   |  | 21b. TIME OF INJURY                                     |  | 21c. HOW INJURY OCCURRED  |  |  |  |
| OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  | HOUR A.M. MONTH DAY YEAR                                |  | (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |
| (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | P.M. 19   |  |   |  |  |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY                                    |  | 21f. LOCATION   |  |  |  |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)          |  | STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (X) (this hospital) attended the deceased from January 14, 1982, to January 15, 1982, that (X) (we) lost saw the deceased alive on January 15, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did not) view the body after death. |  |   |  |   |  |  |  |
| 22b. SIGNATURE  |  |   |  | DEGREE  |  | 22c. DATE SIGNED   |  |
| Harry Harris, M.D.  |  |   |  | M.D.  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   |  | 22e. ADDRESS  |  |  |  |
| HARRY HARRIS, M.D.  |  |   |  | c/o MARYLAND GENERAL HOSPITAL   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION  |  |
| Burial  |  | 1/19/82   |  | Oak Lawn Cemetery   |  | BALTIMORE, Maryland  |  |
| 24. FUNERAL DIRECTOR  |  |   |  | 25a. DATE REC'D. BY REGISTRAR   |  |  |  |
| NAME John St. Moran, Inc.<br>3000 E. Baltimore St.<br>Baltimore, Md. 21224  |  |   |  | JAN 20 1982   |  |  |  |
|   |  |   |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |
|   |  |   |  | [Signature]   |  |  |  |

• 2011

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |  |               |  |   |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                      |  |
|--|--|---------------|--|---|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|----------------------|--|
| 1. FOR STATE REGISTRAR   |  |               |  |   |  |  |  |  |  | 2. DATE KNOWN OF DEATH <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input checked="" type="checkbox"/> ESTI-MATED XX 1 22 19 82 |  |  |  |  |  |  |  |  |  | 2b. HOUR             |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST David Edward Rickels  |  |               |  |   |  |  |  |  |  | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1 26 19 82  |  |  |  |  |  |  |  |  |  | 2d. HOUR 10:30 P. M. |  |
| 3. SEX Male  |  | 4. RACE White |  | 5. DATE OF BIRTH MONTH DAY YEAR 01 25 62  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 20 YRS.          |  | IF UNDER 1 YR. MONTHS DAYS   |  | IF UNDER 24 HRS. HOURS MIN.   |  | 7. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.                         |  |  |  |  |  |  |  |                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland   |  |               |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.   |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  |  |  |  |  |  |  |  |  |                      |  |
| 10. CITY OR TOWN OF DEATH Baltimore  |  |               |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3400 blk. Wilkens Ave. (rear) |  |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machinist   |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY Paper Co.  |  |  |  |  |  |                      |  |
| 13a. STATE Maryland  |  |               |  |   |  |  |  |  |  | 13b. COUNTY ---   |  | 13c. CITY OR TOWN Baltimore  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS 3350 Strickland St., 21229 |  |  |  |                      |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST George Edward Rickels Sr.  |  |               |  |   |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nancy Eugenia Kone   |  |  |  |  |  |  |  |  |  |                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No  |  |               |  | 16b. SOCIAL SECURITY NO. 217-84-8406  |  |  |  | 17. INFORMANT ADDRESS George E. Rickels, Sr. 3350 Strickland St.   |  |   |  |  |  |  |  |  |  |  |  |                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Multiple Gunshot Wounds (handgun)<br>9650<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF                               |  |               |  |   |  |  |  |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |                      |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |               |  |   |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                      |  |
| 19a. DATE OF OPERATION   |  |               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |  |  |   |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |  |  |                      |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |               |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR est. ? P.M. 1 22 19 82   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject was shot   |  |   |  |  |  |  |  |  |  |  |  |                      |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |               |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) field   |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 3400 blk. Wilkens Ave., Balto., Md.   |  |   |  |  |  |  |  |  |  |  |  |                      |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |               |  |   |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                      |  |
| ACTUAL SIGNATURE Virginia L. Dolan   |  |               |  | TITLE (SPECIFY) M.D. Asst.  |  |  |  | MEDICAL EXAMINER   |  |   |  | DATE SIGNED 1-27-82  |  |  |  |  |  |  |  |                      |  |
| EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.  |  |               |  | ADDRESS 111 Penn Street   |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                      |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial   |  |               |  | 23b. DATE 01-30-82  |  | 23c. NAME OF CEMETERY OR CREMATORY Lorraine Park |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn Baltimore Md.  |  |  |  |  |  |  |  |  |  |                      |  |
| 24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc.   |  |               |  | ADDRESS 4107 Wilkens Ave.   |  |  |  | 25a. DATE REC'D. BY REGISTRAR JAN 29 1982  |  |   |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |  |  |  |  |                      |  |

(M)





FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 4 2 0

REG. NO.

|  |  |  |  |   |      |   |  |  |  |  |  |
|--|--|--|--|---|------|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST<br>C.  |  | MIDDLE  | LAST | 2a. DATE OF DEATH MONTH DAY YEAR  |  |  |  | 2b. HOUR                                     |  |
| 3. SEX<br>F  |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Nov. 4, 1896  |      | 6. AGE (IN YEARS LAST BIRTHDAY)<br>85 YRS.  |  |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.    |  |
| 7a. BIRTHPLACE<br>(COUNTRY)<br>MD.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>MARYLAND GENERAL HOSPITAL |  |   |      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>RETIRED                     |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY            |  |
| 13a. STATE<br>MD.  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>BALTO.   |      | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>3137 FAIT AVE.  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>GEORGE DOSCH   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>SARAH BYARD   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |      | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>212-52-6440                          |  | 17. INFORMANT<br>JANE SCHULER  |  | ADDRESS<br>SAME 21224                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION<br>4100<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) SUPRAVENTRICULAR TACHYCARDIA<br>(c) DUE TO, OR AS A CONSEQUENCE OF |  |  |  |   |      |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>MATURITY ONSET DIABETES MELLITUS, CEREBRAL VASCULAR ACCIDENTS   |  |  |  |   |      |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |      | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |      |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |      |   |  |  |  |  |  |
| 22a. I certify that (a) (this hospital) attended the deceased from 12/23/81, 19 81, to January 9, 19 82, that (we) lost saw the deceased alive on January 9, 19 82, and that in (our) opinion death occurred on the date and hour and from the causes stated above (we) (did not) view the body after death.                               |  |  |  |   |      |   |  |  |  |  |  |
| 22b. SIGNATURE<br>Harry M. Harris  |  |  |  |   |      | DEGREE<br>M.D.  |  | 22c. DATE SIGNED   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Harry Harris, M.D.  |  |  |  |   |      | 22e. ADDRESS  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(a) (b) (c)   |  | 23b. DATE<br>1-12-82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>OAKLAWN CEM.  |      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO. MD.  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>HOFFMANN F.H.  |  |  |  |   |      | ADDRESS<br>3218 HUDSON ST.  |  | 25a. DATE RECEIVED BY REGISTRAR<br>JAN 15 1982   |  | 25b. REGISTRAR'S SIGNATURE                   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



MEMORANDUM

DATE: 10/14/58  
TO: MR. A. J. B. A.  
FROM: MR. A. J. B. A.

RE: [illegible]

1. [illegible]  
2. [illegible]  
3. [illegible]  
4. [illegible]  
5. [illegible]

6. [illegible]  
7. [illegible]  
8. [illegible]

9. [illegible]  
10. [illegible]



11. [illegible]  
12. [illegible]

13. [illegible]  
14. [illegible]

15. [illegible]  
16. [illegible]  
17. [illegible]  
18. [illegible]  
19. [illegible]  
20. [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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2

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  | 2a. DATE OF DEATH  |  |  | 2b. HOUR   |  |  |
| ROSE  |  |  | JANUARY 9, 1982  |  |  | 3:16pm   |  |  |
| 3. SEX  |  |  | 4. RACE  |  |  | 5. DATE OF BIRTH   |  |  |
| F   |  |  | W  |  |  | 3/15/14  |  |  |
| 7a. BIRTHPLACE<br>(COUNTRY)   |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |
| Mich.   |  |  | U.S.A.   |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION                |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |  |
| Balto.  |  |  | Church Home Hos.   |  |  | Housewife  |  |  |
| 12b. KIND OF BUSINESS OR INDUSTRY   |  |  | 13a. STATE   |  |  | 13b. COUNTY  |  |  |
| Res.  |  |  | Md.  |  |  | Balto.   |  |  |
| 13c. CITY OR TOWN   |  |  | 13d. INSIDE CITY LIMITS?   |  |  | 13e. STREET ADDRESS  |  |  |
| Balto.  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>    |  |  | 23 S. Broadway   |  |  |
| 14. FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME   |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?   |  |  |
| Steve John Stevens  |  |  | Butchericka Miller   |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> (IF YES, GIVE WAR OR DATES)  |  |  |
| 16b. SOCIAL SECURITY NO.  |  |  | 17. INFORMANT  |  |  | 17. ADDRESS  |  |  |
| No  |  |  | Mrs Fatima Ristick   |  |  | 23 S. Broadway   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u><br>4275<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>RESPIRATORY ARREST</u><br>(c) <u>CARDIAC ARRYTHMIA (ASYSTOLE)</u> |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|   |  |  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/9, 1982, to 1/9, 1982, that (I) (we) last saw the deceased alive on 1/9, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE  |  |  | DEGREE   |  |  | 22c. DATE SIGNED   |  |  |
| E. V. Platia MD   |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  | 22e. ADDRESS   |  |  |  |  |  |
| E.V. PLATIA, M.D.   |  |  | 100 N BROADWAY, BALTIMORE, MD. 21231                                   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  |  | 23b. DATE  |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  |
| Burial  |  |  | 1/13/82  |  |  | Western cem. Edmondson ave. Balto. Md.   |  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |  | 24. FUNERAL DIRECTOR   |  |  | 25a. DATE REC'D. BY REGISTRAR  |  |  |
|   |  |  | NAME ADDRESS   |  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |
|   |  |  | Dad + Son 322 S. HIGH ST.  |  |  | JAN 12 1982  |  |  |



12/14

ORIGINAL FILED  
BAND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |   |  |   |  |                                   |  |
|--|--|--|--|---|--|---|--|-----------------------------------|--|
| 1- FOR STATE REGISTRAR   |  |  |  |   | 8 2 0 1 4 2 2  |   |  |                                   |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  |  |   | 2a. DATE OF DEATH  |   |  |                                   |  |
| FIRST MIDDLE LAST  |  |  |  |   | MONTH DAY YEAR   |   |  |                                   |  |
| Albert Emory Ritter  |  |  |  |   | 1/3/82 1 3 82  |   |  |                                   |  |
| 3 SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                               |  | 7b. HOUR                          |  |
| Male   |  | Caucasian  |  | Jan. 23, 1904   |  | 77 YRS.   |  | 10:15 AM                          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                          |  |                                   |  |
| Maryland   |  | USA  |  |   |  | Balto. City MD.   |  |                                   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| Balto.   |  | Union Memorial Hospital  |  |   |  | Electrical Contractor   |  | Resd                              |  |
| 13a. STATE   |  |  |  |   | 13b. COUNTY  |   |  |                                   |  |
| Maryland   |  |  |  |   | Baltimore  |   |  |                                   |  |
| 13c. CITY OR TOWN  |  |  |  |   | 13d. INSIDE CITY LIMITS?   |   |  |                                   |  |
| Catonsville  |  |  |  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |  |                                   |  |
| 14. FATHER'S NAME  |  |  |  |   | 15. MOTHER'S MAIDEN NAME   |   |  |                                   |  |
| Tillison Emory Ritter  |  |  |  |   | Cora Sinclair  |   |  |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |  |   | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT ADDRESS  |                                   |  |
| No   |  |  |  |   | N/A  |   | 6613 Johnnycake  |                                   |  |
|  |  |  |  |   | 214-16-8806  |   | Mr. Edgar Ebberts Jr. Balt., Md 21207                          |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary over</u><br><u>4241</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Axilla-fem. hypers</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |  |   |  |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><u>Axilla-fem hypers acute, Duodenal Perforation</u>   |  |  |  |   |  |   |  |                                   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 19c. AUTOPSY?  |   | 19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                                   |  |
| 12/18/81   |  | Infected cardiac graft   |  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |                                   |  |
|  |  | HOUR A.M. MONTH DAY YEAR   |  |   |  |   |  |                                   |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION   |  |   |  |                                   |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  | CITY OR TOWN COUNTY STATE   |  |   |  |                                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/3/82</u> 19 <u>82</u> to <u>1/3/82</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>1/3</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |                                   |  |
| 22b. SIGNATURE   |  |  |  |   | DEGREE   |   |  | 22c. DATE SIGNED                  |  |
| <u>Sergio Anzisi</u>   |  |  |  |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |  | 1/3/82                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  |   | 22e. ADDRESS   |   |  |                                   |  |
| SERGIO ANZISI  |  |  |  |   | 201 E. University Pkwy   |   |  |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION   |  |                                   |  |
| Burial   |  | 1/6/82   |  | Old Salem Cemetery  |  | CITY OR TOWN COUNTY STATE                                     |  |                                   |  |
|  |  |  |  |   |  | Catonsville Balt., Md.  |  |                                   |  |
| 24. FUNERAL DIRECTOR   |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR  |   |  |                                   |  |
| MacNabb Funeral Home   |  |  |  |   | 25b. REGISTRAR'S SIGNATURE   |   |  |                                   |  |
| Edward MacNabb   |  |  |  |   | JAN 4 1982   |   |  |                                   |  |



RECEIVED  
JAN 10 1914  
U.S. DEPT. OF AGRICULTURE  
OFFICE OF THE SECRETARY



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 1-72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 4 2 3

REG. NO.

|   |  |   |   |   |  |  |   |  |  |  |
|---|--|---|---|---|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Ernest Rivers</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1/10/82</b>                     |   |  | 2b. HOUR<br><b>6:00 AM</b>   |   |  |  |  |
| 3. SEX<br><b>male</b>   |  | 4. RACE<br><b>Negro</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9/7/06</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS.  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>75</b>  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>North Carolina</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University of Maryland Hospital</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>maintenance</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>church</b>   |  |  |
| 13a. STATE<br><b>Maryland</b>   |  |   | 13b. COUNTY   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>                      |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>750 Grantley Rd.</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James Rivers</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Sylvia Bloomfield</b> |   |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>no</b>   |  |   | 16b. SOCIAL SECURITY NO.<br><b>218-09-0329</b>                            |   | 17. INFORMANT<br><b>Delarees Thacker</b>                   |  | ADDRESS<br><b>750 Grantley Rd., Baltimore</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiopulmonary arrest</b><br><b>1539</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>metastatic colon cancer</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6 months</b> |  |   |   |   |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:<br><b>anemia</b>   |  |   |   |   |  |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>6/3/81</b>   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>colon cancer</b>   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>         |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)    |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from <b>1/7</b> , 19 <b>82</b> , to <b>1/10</b> , 19 <b>82</b> , that (we) lost<br>saw the deceased alive on <b>1/10</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |   |   |   |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Umar Atabek</b>  |  |   | DEGREE<br><b>MD</b>   |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>1/10/82</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Umar Atabek</b>   |  |   | 22e. ADDRESS<br><b>University Hospital, 22 S. Greene St., Baltimore</b>   |   |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |   | 23b. DATE<br><b>1/16/82</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King mem. Pk.</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Co. MD</b>                              |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H 1101 E. North Ave.</b>  |  |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 11 1982</b>        |  |   |  |  |  |
|   |  |   |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Phoness Jan Nathan</b>    |  |   |  |  |  |



12

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or one of the following must be completed.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   | 8 2 0 1 4 2 4   |   |   |   |   |  |   |                                   |  |  |
|---|--|---|--|---|---|---|---|---|---|--|---|-----------------------------------|--|--|
| FOR<br>1. STATE<br>REGISTRAR  |  |   |  |   | REG. NO.  |   |   |   |   |  |   |                                   |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Chester</b> <b>Robinson</b>  |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1/10/82</b>                         |   |   |   |   | 2b. HOUR<br><b>4 15 P.M.</b>   |   |                                   |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1-21-95</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>85</b> YRS.                 |   |   | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS<br>HOURS MIN.   |                                   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD. |   |   |   |  |   |                                   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Edgewood Nursing Home</b> |  |   |   |   |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |   | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |
| 13a. STATE<br><b>MD</b>   |  |   |  |   | 13b. COUNTY   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>                                 |   | 13d. INSIDE CITY LIMITS?<br><b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>6000 Bellona Ave.</b><br><b>Edgewood Nursing Home</b> |                                   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James Robinson</b>   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Rosie</b>                 |   |   |   |   |  |   |                                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  |   |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>215-01-2196</b> |   | 17. INFORMANT<br>ADDRESS<br><b>Mary Whitlor 626 N. Augusta Avenue</b> |   |   |  |   |                                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Rectal Adenocarcinoma of the rectum</b><br><b>1541</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>mass. - Gastric - Cancer resection</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Left Side Colostomy Area Anemia</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |   |   |   |   |   |   |  |   |                                   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)  |  |   |  |   |   |   |   |   |   |  |   |                                   |  |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   |   | 20a. AUTOPSY?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/> |   |                                   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)          |   |  |   |                                   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                       |   |  |   |                                   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 31</b> , 19 <b>79</b> , to <b>Jan 10</b> , 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>Jan 8</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                       |  |   |  |   |   |   |   |   |   |  |   |                                   |  |  |
| 22b. SIGNATURE<br><b>Mannel Sodaro M.D.</b>   |  |   |  |   |   |   |   | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED   |   |                                   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Mannel Sodaro M.D.</b>  |  |   |  |   |   |   |   | 22e. ADDRESS<br><b>4624 York Rd - 2142</b>  |   |  |   |                                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>  |  |   |  | 23b. DATE<br><b>1/16/82</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cem.</b>      |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co. MD</b>   |  |   |                                   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H</b>   |  |   |  |   |   |   |   | ADDRESS<br><b>1101 E. North Ave.</b>  |   | 25a. DATE REC'D. BY REGISTRAR (BY REGISTRAR'S SIGN)<br><b>JAN 14 1982</b> <b>James Santhorne</b>   |   |                                   |  |  |

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۱- در صورتی که در یک سال دو بار یا بیشتر از آن  
 به دلیل بیماری، استراحت کند و یا به هر دلیل دیگر  
 نتواند به کار خود ادامه دهد، باید با اطلاع مدیر  
 امور پرسنل، درخواست مرخصی نماید.

10-11-12

Sept 25 - High Island, 1887

with 1000 cc. 50% alcohol

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |   |  |  |   |  |  |   | 8   | 2 | 0   | 1 | 4  | 2   | 5 |   |  |  |
|---|--|--|---|--|--|---|--|--|---|---|---|---|---|--|---|---|---|--|--|
| 1- FOR STATE REGISTRAR  |  |  |   |  |  |   |  |  |   | REG. NO.  |   |   |   |  |   |   |   |  |  |
| 1 DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Daisy NMN Robinson</b>   |  |  |   |  |  |   |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>Jan. 6, 1982</b>                           |   |   |   | 2b. HOUR MIN.<br><b>8:40 PM</b>  |   |   |   |  |  |
| 3 SEX<br><b>Female</b>  |  |  | 4 RACE<br><b>Black</b>  |  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>6 23 10</b>   |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS.                 |   |   | 7. IF UNDER 1 YEAR MONTHS DAYS<br><b>0 0</b>  |   | 7b. IF UNDER 24 HRS. HOURS MIN.<br><b>0 0</b>  |   |   |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Andrew, S.C.</b>  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD. |   |   |   |   |  |   |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. AGNES HOSPITAL</b> |  |  |   |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)     |   |   | 12b. KIND OF BUSINESS OR INDUSTRY   |   |  |   |   |   |  |  |
| 13a. STATE<br><b>MD</b>   |  |  |   |  |  |   |  |  |   | 13b. COUNTY   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |   | 13e. STREET ADDRESS<br><b>1201 S. Hanover St.</b> |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Peter Johnson</b>   |  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Lavania Johnson</b>   |   |  |  |   |   |   |   |   |  |   |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>  |  |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>212-01-8955</b>   |   |  |  |   | 17. INFORMANT ADDRESS<br><b>Celeste Evans 4539 Marble Hall Road</b>               |   |   |   |  |   |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hypoxia - Probable Brain Metastase</b><br>1749 } DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Metastatic breast carcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Rt pleural effusion -</b> |  |  |   |  |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                      |   |   |   |  |   |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><b>Rt pleural effusion -</b>  |  |  |   |  |  |   |  |  |   |   |   |   |   |  |   |   |   |  |  |
| 19a. DATE OF OPERATION  |  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |  |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |   |   |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  |  |   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   |  |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)    |   |   |   |  |   |   |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   |  |  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                    |   |   |   |  |   |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1-4</b> <b>82</b> to <b>1-6</b> <b>82</b> saw the deceased alive on <b>1-6</b> <b>82</b> , and that in (my) (aur) apinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.       |  |  |   |  |  |   |  |  |   |   |   |   |   |  |   |   |   |  |  |
| 22b. SIGNATURE<br><b>Bah T Duong</b>  |  |  |   |  | DEGREE<br><b>M.D.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |  |  |   | 22c. DATE SIGNED<br><b>1-6-82</b>   |   |   |   |  |   |   |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. DUONG</b>   |  |  |   |  | 22e. ADDRESS<br><b>ST AGNES HOSPITAL</b>   |   |  |  |   |   |   |   |   |  |   |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |  |   |  | 23b. DATE<br><b>1/12/82</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MD. VETERANS CEM.</b> |  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Crownsville MD</b>                  |   |   |   |  |   |   |   |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Wm. C. March F/H, Inc.</b>  |  |  |   |  |  |   |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 8 1982</b>                                |   |   |   |  | 25b. REGISTRAR SIGNATURE<br><i>James J. [Signature]</i> |   |   |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO. 8201426  |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  |   |  |   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Flora F Robinson   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>1-28-82   |  | 2b. HOUR<br>M   |  |
| 3. SEX<br>F  |  | 4. RACE<br>B I K  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>5-5-08   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br>73  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>V.A   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>City MD   |  |
| 10. CITY OR TOWN OF DEATH<br>Balt  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>755 Edgewood Rd |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |
| 13a. STATE<br>Md   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Balt   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>TASHER JACKSON  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Rosalind  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>-   |  | 17. INFORMANT ADDRESS<br>Benjamin Powell 4411 Wakefield   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 3319 Sepsis - infected Decubid Ulcer<br>(b) Dehydration<br>(c) Cerebral atrophy - senile dementia<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br>Cerebral vasculature accident & contractions. Low re. EX |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 06-12 1981 to 01-28 1982, that (I) (we) lost saw the deceased alive on 11/24 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br>R. Williams  |  |   |  | DEGREE<br>MD  |  | 22c. DATE SIGNED<br>02/01/82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Robert J Williams   |  |   |  | 22e. ADDRESS<br>4200 Edmonson Ave Balt MD 21229   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>2-2-82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>St. John Cem  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Kilmonick  |  |
| 24. FUNERAL DIRECTOR NAME<br>VERNON R. Bailey  |  |   |  | ADDRESS<br>1348 N. Calhoun  |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 5 1982   |  |
|  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br>James J. Martin   |  |   |  |



1985  
J. L. Smith



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 50M/1/B1  
(VRA 15, 4)

Item 1g564 2/2/82 gj

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

8 2 0 1 4 2 7

CERTIFICATE OF DEATH

REG. NO.

|   |  |  |   |   |                          |  |
|---|--|--|---|---|--------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST (AKA James Ross) MIDDLE LAST<br><b>JAMES ROBERT ROBINSON</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 29 82</b> |   | 2b. HOUR<br><b>7:20p</b> |  |
| 3 SEX<br><b>MALE</b>  |  | 4 RACE<br><b>BLACK</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 18 10</b>  |                          |  |
| 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b>   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY,</b>   |                          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 12a. USUAL OCCUPATION (WORKING LIFE)<br><b>Retired</b>  |                          |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><b>VETERANS ADMINISTRATION MEDICAL CENTER</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY   |                          |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>BALTO.</b>   |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |                          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Will Ross</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Estell Robinson</b>  |   | 16. SOCIAL SECURITY NO.<br><b>218-14-5005</b>   |                          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>218-14-5005</b>   |   | 17. ADDRESS<br><b>VAMC Medical Records 3900 LOCH RAVEN BLVD</b>   |                          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiomegaly / biventricular dilation</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Pulmonary congestion / edema (by autopsy)</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>5140</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |   |   |                          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.<br><b>Carcinomatosis Ascending Colon</b>  |  |  |   |   |                          |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |                          |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                          |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>JANUARY 29</b> 19 <b>82</b> to <b>JANUARY 29</b> 19 <b>82</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>JANUARY 29</b> 19 <b>82</b> , and that in <b>XX</b> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <b>XXXX</b> view the body after death. |  |  |   |   |                          |  |
| 22b. SIGNATURE<br><b>Maura Doherty</b>  |  | DEGREE   |   | 22c. DATE SIGNED<br><b>1/31/82</b>  |                          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Maura Doherty</b>   |  | 22e. ADDRESS<br><b>3900 LOCH RAVEN BLVD BALTO, MD 21218</b>  |   | 22f. MEDICAL <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(IF ANY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>2-3-82</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Crownsville Let Cem.</b>   |                          |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Joseph L. Russ</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 1 1982</b>   |   | 25b. REGISTRAR<br><b>Frances Santhorne</b>  |                          |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be retained within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified on page 3.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |  |  | REG. NO.  |  |
|---|--|---|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>RICHARD ROBINSON</b>   |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JANUARY 9, 1982</b>                                   |  |  |  | 2b. HOUR<br><b>7:48 P M</b>   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 3 1910</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MARYLAND GENERAL HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret. Custodian</b>       |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |
| 13a. STATE<br><b>Md</b>   |  | 13b. COUNTY<br><b>Balto</b>   |  | 13c. CITY OR TOWN<br><b>Balto</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1436 Argyle Ave.</b>   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>? ? ?</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mattie ?</b>  |  |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>217 09 0891</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Richard Robinson Jr. 1710 Fulton Ave.</b>                        |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ASPIRATION OF GASTRIC CONTENTS WITH ASPIRATION</b><br><b>5070</b><br><b>PNEUMONIA (1 DIFFUSE PROBABLE 2 DEGREE TO</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>SEIZURES</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b> |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that (X) (this hospital) attended the deceased from <b>December 30, 1981</b> to <b>January 9, 1982</b> , that (X) (we) lost<br>saw the deceased alive on <b>January 9, 1982</b> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (X) (we) did (X) (not) view the body after death.           |  |   |  |   |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Huang-Ta Lin</b>   |  |   |  | DEGREE<br><b>M.D.</b>   |  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Huang-Ta Lin, M.D.</b>  |  |   |  | 22e. ADDRESS  |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |   |  | 23b. DATE<br><b>1-13-82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview Mem. Pk.</b>                                  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Brown/Thompson F.H. 1913 W. Balto. St.</b>   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 11 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Thom. J. Smith</b>  |  |   |  |



NOTICE

Faint, mostly illegible text covering the page, possibly a notice or official document. Some visible words include "NOTICE", "DEPARTMENT OF", "OFFICE", "BY", "DATE", "SIGNED", "WITNESSED", "IN WITNESS WHEREOF", "AT THE CITY OF", "COUNTY OF", "STATE OF".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem held at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |                            |  |  |
|---|--|---|--|---|--|--|----------------------------|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  |   | REG. NO.   |  |                            |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <u>WILLIE</u> <u>WILLIE</u> <u>ROBINSON</u>   |  |   |  |   | 2a. DATE OF DEATH<br>MONTH <u>1</u> DAY <u>30</u> YEAR <u>82</u>   |  | 2b. HOUR<br><u>3:30 PM</u> |  |  |
| 3. SEX<br><u>MALE</u>   |  | 4. RACE<br><u>BLACK</u>   |  | 5. DATE OF BIRTH<br>MONTH <u>08</u> DAY <u>18</u> YEAR <u>63</u>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>78</u> YRS.                                    |                            | IF UNDER 1 YEAR<br>MONTHS <u></u> DAYS <u></u>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>UNKNOWN</u>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>Baltimore City</u> MD.                    |                            |  |  |
| 10. CITY OR TOWN OF DEATH<br><u>DARTMOUTH</u>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>University Hospital</u> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     |                            | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |   |  |  |                            |  |  |
| 13a. STATE<br><u>MD</u>   |  | 13b. COUNTY<br><u>Baltimore</u>   |  | 13c. CITY OR TOWN<br><u>Baltimore</u>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                            | 13e. STREET ADDRESS<br><u>322 Mt. Holly St.</u>  |  |
| 14. FATHER'S NAME<br>FIRST <u>Robert</u> MIDDLE <u></u> LAST <u></u>  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <u>Nancy</u> MIDDLE <u></u> LAST <u></u>   |  |                            |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.<br><u>213-10-3206</u>  |  | 17. INFORMANT<br><u>Delores Robinson</u> ADDRESS<br><u>322 N. Mt. Holly St.</u>   |  |  |                            |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardiac arrest</u><br><u>5579</u> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <u>sepsis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>ischemic Bowel</u> |  |   |  |   |  |  |                            |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>  |  |   |  |   |  |  |                            |  |  |
| 19a. DATE OF OPERATION<br><u>1/29/82</u>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>ischemic Bowel</u>   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><u>P.M.</u> <u>19</u>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><u>w/a</u>  |  |  |                            |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |                            |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/30</u> 19 <u>82</u> , to <u>1/30</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>1/30</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                              |  |   |  |   |  |  |                            |  |  |
| 22b. SIGNATURE<br><u>Bruce Balf</u> M.D.  |  |   |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |                            | 22c. DATE SIGNED   |  |
| 22a. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Bruce Balf</u>  |  |   |  |   | 22b. ADDRESS<br><u>22 S. Greene St. Baltimore MD</u>   |  |                            |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Burial</u>  |  | 23b. DATE<br><u>2/3/82</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Garden of Eternal Hope</u>   |  | 23d. LOCATION<br>CITY OR TOWN <u>Balto.</u> COUNTY <u>md.</u> STATE <u></u>          |                            |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <u>Leroy A. Lytt</u> ADDRESS <u>4600 Liberty St.</u>   |  |   |  |   | 25. FILED BY REGISTRAR<br><u>1982</u> <u>James J. Thornton</u>   |  |                            |  |  |



FORWARDED TO THE  
DIRECTOR, BUREAU OF  
RECORDS & COMMUNICATIONS

RECEIVED BY THE  
BUREAU OF RECORDS & COMMUNICATIONS

RECEIVED BY THE  
BUREAU OF RECORDS & COMMUNICATIONS

RECEIVED BY THE  
BUREAU OF RECORDS & COMMUNICATIONS

RECEIVED BY THE  
BUREAU OF RECORDS & COMMUNICATIONS

1001



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 8 2 0 1 4 3 0  |  |  |  |
|---|--|--|--|--|--|--|--|
| FOR<br>1. STATE<br>REGISTRAR  |  |  |  | CERTIFICATE OF DEATH   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  |  | 2a. DATE OF DEATH  |  |  |  |
| JACQUELINE E. ROE   |  |  |  | JANUARY 11, 1982   |  |  |  |
| 3. SEX<br>F   |  |  |  | 4. RACE<br>W   |  |  |  |
| 5. DATE OF BIRTH<br>10/4/35   |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>46  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>PA.  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  |  |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTO. CITY MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTO.   |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>CHURCH HOSP |  |  |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HSWE  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD  |  |  |  | 13b. COUNTY<br>BALTO   |  |  |  |
| 13c. CITY OR TOWN<br>DUNDALK  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |  |  |  |
| 13e. STREET ADDRESS<br>1919 PENHALL RD  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>MARTIN TROXELL  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>EMMA LARSON   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  |  |  | 16b. SOCIAL SECURITY NO.<br>21734-6154   |  |  |  |
| 17. INFORMANT<br>ADDRESS<br>FORREST ROE ABOVE   |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u><br>1539<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>METASTASIS FROM CARCINOMA OF COLON</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) |  |  |  |  |  |  |  |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  |  |  |  |  |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  |  |  |  |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |  |  |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  |  |  |  |  |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  |  |  |  |  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  |  |  |  |  |  |
| 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  |  |  |  |  |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>JANUARY 5</u> , 19 <u>82</u> , to <u>JANUARY 11</u> , 19 <u>82</u> , that (I) (we) lost<br>saw the deceased alive on <u>JANUARY 11</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) did (did not) view the body after death.   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br>Y. K. SHETTY  |  |  |  |  |  |  |  |
| DEGREE<br>MD  |  |  |  |  |  |  |  |
| 22c. DATE SIGNED<br>1/11/82   |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Y. K. SHETTY   |  |  |  |  |  |  |  |
| 22e. ADDRESS<br>CHURCH HOSPITAL CORPORATION<br>MD. 100 BROADWAY 21231 BALTIMORE MD.   |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  |  |  |  |  |  |  |
| 23b. DATE<br>1/13/82  |  |  |  |  |  |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br>OAK LAWN  |  |  |  |  |  |  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO. MD.  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>J. J. Connelly 300 Main Ave   |  |  |  |  |  |  |  |
| 25a. DATE REC'D. BY REGISTRAR<br>JAN 19 1982  |  |  |  |  |  |  |  |
| 25b. REGISTRAR'S SIGNATURE<br>James J. Connelly   |  |  |  |  |  |  |  |



100-100000

TO THE HONORABLE THE ATTORNEY GENERAL  
STATE OF NEW YORK  
FROM THE  
[Illegible Name]  
[Illegible Address]  
[Illegible City]  
[Illegible State]  
[Illegible Zip]  
[Illegible Title]  
[Illegible Date]  
[Illegible Subject]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                  |  |   |  |   |  |   |  | REG. NO. 7201431   |  |   |  |                                |  |   |  |   |  |
|--|--|------------------|--|---|--|---|--|---|--|--|--|---|--|--------------------------------|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Mary Ellen Roe  |  |                  |  |   |  |   |  |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br>1 20 1982 |  | 2b. HOUR<br>M<br>A. M.  |  |                                |  |   |  |   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11 17 25  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS.<br>56     |  | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.   |  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>1 20 1982  |  | 7d. HOUR<br>11:30<br>A. M.  |  |                                |  |   |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>West Virginia   |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                         |  |                                |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3819 Wilkens Avenue |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Salesperson  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Real Estate   |  |   |  |                                |  |   |  |   |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |                  |  |   |  |   |  |   |  | 13a. STATE<br>Maryland   |  | 13b. CITY OR TOWN<br>---  |  | 13c. CITY OR TOWN<br>Baltimore |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>3819 Wilkens Avenue, 21229 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>H. C. Atwell   |  |                  |  |   |  |   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Bessie Hager  |  |   |  |                                |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No  |  |                  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>226-32-4718  |  |   |  | 17. INFORMANT<br>ADDRESS<br>Donald W. Shuler 3819 Wilkens Avenue 21229  |  |  |  |   |  |                                |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 9550 Gunshot wound to Chest (handgun)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.   |  |                  |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |                                |  |   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 18.   |  |                  |  |   |  |   |  |   |  |  |  |   |  |                                |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |  |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                                |  |   |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>? P.M. 1 20 1982   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>subject shot herself   |  |  |  |   |  |                                |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>Home   |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>3819 Wilkens Avenue, Balto, Maryland   |  |  |  |   |  |                                |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above; held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                  |  |   |  |   |  |   |  |  |  |   |  |                                |  |   |  |   |  |
| ACTUAL SIGNATURE<br>Virginia L. Dolan  |  |                  |  | TITLE (SPECIFY)<br>M.D. Assistant   |  |   |  | MEDICAL EXAMINER  |  |  |  | DATE SIGNED<br>1-20-82  |  |                                |  |   |  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Virginia L. Dolan, M.D.  |  |                  |  | ADDRESS<br>111 Penn Street  |  |   |  |   |  |  |  |   |  |                                |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation  |  |                  |  | 23b. DATE<br>01-25-82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore City Maryland                                |  |   |  |                                |  |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Hubbard Funeral Home, Inc.   |  |                  |  | ADDRESS<br>21229<br>4107 Wilkens Ave.   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 22 1982  |  |  |  |   |  |                                |  |   |  |   |  |



2005-10-10

2005-10-10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 2 0 1 4 3 2   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>GERALD M. ROEDEL</b>   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 24 82</b>   |  | 2b. HOUR<br><b>8:30 AM</b>   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 26 37</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>44</b> YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balt City</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>154 Agnes</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Op Instruction Tech.</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>B. G. &amp; E.</b>   |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Arbutus</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 13e. STREET ADDRESS<br><b>5550 Dolores Avenue</b>   |  | 13f. CITY OR TOWN<br><b>21227</b>   |  | 14. FATHER'S NAME<br>FIRST MIDDLE<br><b>Joseph Roedel</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE<br><b>Josephine Gurel</b>   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>216-34-3838</b>  |  | 17. INFORMANT<br><b>Dorothy M. Roedel</b>   |  | ADDRESS<br><b>5550 Dolores Ave. 21227</b>  |  |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART 1: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ACUTE PULMONARY EDEMA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ACUTE MYOCARDIAL INFARCTION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>CORONARY ATHEROSCLEROSIS</b><br>4100<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Michael E. Pelczar</b>   |  |   |  | DEGREE<br><b>ATTENDING PHYSICIAN</b>  |  | 22c. DATE SIGNED<br><b>1/24/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MICHAEL E. PELCZAR</b>  |  |   |  | 22e. ADDRESS  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>1/28/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Hubbard Funeral Home, Inc. 4107 Wilkens Ave.</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 25 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>James Van Nostrand</b>  |  |



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial permit. Then please return the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified on page 2.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO.   |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  | 8 2 0 1 4 3 3  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  |  | 2a. DATE OF DEATH  |  |  |  |
| FIRST MIDDLE LAST<br>CHARLES B. ROGERS  |  |  |  | MONTH DAY YEAR<br>01/ 01/82  |  |  |  |
| 3. SEX  |  |  |  | 2b. HOUR   |  |  |  |
| MALE  |  |  |  | 4:55A  |  |  |  |
| 4. RACE   |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  |  |  |
| WHITE   |  |  |  | 67   |  |  |  |
| 5. DATE OF BIRTH  |  |  |  | IF UNDER 1 YEAR  |  |  |  |
| MONTH DAY YEAR<br>AUG. 31 1914  |  |  |  | MONTHS DAYS HOURS MIN.   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |  |  |
| NEW MEXICO  |  |  |  | BALTIMORE CITY MD.   |  |  |  |
| 7b. CITIZEN OF WHAT COUNTRY?  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                  |  |  |  |
| U.S.A.  |  |  |  | ELECTRICIAN  |  |  |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  |  | CONSTRUCTION   |  |  |  |
| BALTIMORE   |  |  |  |  |  |  |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  |  |  |  |  |  |  |  |
| JOHNS HOPKINS HOSPITAL  |  |  |  |  |  |  |  |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |  |  |  |  |
| 13a. STATE 13b. COUNTY 13c. CITY OR TOWN  |  |  |  |  |  |  |  |
| MARYLAND HARFORD DARLINGTON   |  |  |  |  |  |  |  |
| 14. FATHER'S NAME   |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |
| BARKER C. ROGERS  |  |  |  | MABEL BARKER   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |  | 17. INFORMANT ADDRESS  |  |  |  |
| YES WWII  |  |  |  | PAULINE E. ROGERS, DARLINGTON, MARYLAND  |  |  |  |
| 16b. SOCIAL SECURITY NO.  |  |  |  |  |  |  |  |
| 441-05-4397   |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                   |  |  |  |
| IMMEDIATE CAUSE (a) CARDIAL ARREST  |  |  |  | 15 seconds   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) RESPIRATORY ARREST/DETERIORATION   |  |  |  | 6 hours  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) PROBABLE GRAM NEGATIVE SEPSIS  |  |  |  | 24 hours   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                               |  |  |  |
| 20a. AUTOPSY?   |  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?                 |  |  |  |
| YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |
| 21d. INJURY OCCURRED  |  |  |  | 21f. LOCATION  |  |  |  |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  |  | CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/7, 1981, to 1/1, 1982, that (I) (we) last saw the deceased alive on 1/1, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE  |  |  |  | 22c. DATE SIGNED   |  |  |  |
| JOSEPH M. AHEARN MD   |  |  |  | 1/1/82   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | 22e. ADDRESS   |  |  |  |
| JOSEPH M. AHEARN  |  |  |  | JOHNS HOPKINS HOSPITAL   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  |  | 23b. DATE  |  |  |  |
| BURIAL  |  |  |  | JAN. 5, 1982   |  |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY  |  |  |  | 23d. LOCATION  |  |  |  |
| BEL AIR MEMORIAL GDNS.  |  |  |  | CITY OR TOWN COUNTY STATE<br>BEL AIR, HARFORD CO., MD.                         |  |  |  |
| 24. FUNERAL DIRECTOR  |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  |  |  |
| JOHN M. HARKINS 600 MAIN ST., DELTA, PA.  |  |  |  | JAN 5 1982   |  |  |  |
|   |  |  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |
|   |  |  |  | [Signature]  |  |  |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 4 3 4

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |   |   |   |  |
|---|--|--|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>EARL F Rogers</b>  |  |  | 2a. DATE OF DEATH<br>MONTH <b>1</b> DAY <b>14</b> YEAR <b>82</b> |   |   | 2b. HOUR<br><b>9:45 AM</b>  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>COL</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>JULY</b> DAY <b>23</b> YEAR <b>1923</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>58</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>BALTIMORE MD</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD</b>                                |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>PROVIDENT HOSP</b>                   |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>CONS. WORKER</b>         |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>CONS</b>  |  |  |  |   |   |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |   |   |   |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 13e. STREET ADDRESS<br><b>1153 N. CAREY ST</b>  |  |  |  |   |   |   |  |
| 14. FATHER'S NAME<br>FIRST <b>UNKNOWN</b> MIDDLE <b>UNKNOWN</b> LAST <b>UNKNOWN</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>BERTHA</b> MIDDLE <b>UNKNOWN</b> LAST <b>UNKNOWN</b>   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>219-12 2969</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>MISS SYLVIA PAYNE 1731 N. CAREY ST</b>   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO RESPIRATORY ARREST</b><br><b>1539</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>DEHYDRATION</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <b>CARCINOMA OF COLON.</b> |  |  |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>ALCOHOLISM</b>  |  |  |  |   |   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |
| 22a. I certify that (I (this hospital) attended the deceased from <b>Jan 14, 1982</b> , to <b>Jan 18, 1982</b> , that (I (we) last saw the deceased alive on <b>Jan 14, 1982</b> , and that in (my (our) opinion death occurred on the date and hour and from the causes stated above, (I (we) did (did not) view the body after death.   |  |  |  |   |   |   |  |
| 22b. SIGNATURE<br><b>A. Miranda, MD</b>   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |   |   | 22c. DATE SIGNED<br><b>1/14/82</b>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>A. MIRANDA, MD</b>  |  | 22e. ADDRESS<br><b>PROVIDENT HOSPITAL</b>  |  |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>1-20-82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ARBUTUS MEM PL</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ARBUTUS BALTO Co MD</b>                        |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>JOSEPH L. RUSS 2222 W. NORTH AVE</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 18 1982</b>   |   |   |  |
|   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Shane J. [Signature]</b>   |   |   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

WILSON

1910

Unknown

Unknown

Unknown

Unknown

Unknown

Unknown

Unknown

Unknown

Unknown

Unknown

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8 2 0 1 4 3 5  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |   |  | REG. NO.   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Eleanor Lee Crabill Rohrer</b>   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>1-15-82</b>   |  | 2b. HOUR<br><b>8 A M</b>  |  |
| 3 SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>3 4 11</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore City</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Mercy Hospital</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  |   |  | 13b. COUNTY<br><b>-</b>  |  | 13c. CITY OR TOWN<br><b>City-Balto</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Jacob Crabill</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Virginia Funk</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br><b>---</b>  |  | 17. INFORMANT ADDRESS<br><b>Mrs. H. Vincent Grove 520 W. King St. Martinsburg, West Virginia</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute respiratory failure</b><br>4960<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Severe chronic obstructive pulmonary disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>811 mi. knee hip fracture (O) chronic bronchitis</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>-</b> |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION<br><b>-</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>-</b>  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/23</b> , 19 <b>81</b> , to <b>1/15</b> , 19 <b>82</b> , that (I) (we) lost the deceased above on <b>8:15 am 1/15</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Behime Bose M.D.</b>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                   |  | 22c. DATE SIGNED<br><b>1-15-82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Pratima Bose</b>   |  |   |  | 22e. ADDRESS<br><b>301 St. Paul Place Balto, Md 21202</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>Jan. 18, 82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Toms Brook Cem.</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Toms Brook, West Virginia</b>   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>William E. Johnson</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 18 1982</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>James San Nathan</b>   |  |

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1-13-62

Missor Lee Campbell

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 330.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 8 2 0 1 4 3 6   |  |
|---|--|---|--|---|--|
| 1- FOR STATE REGISTRAR  |  |   |  | REG. NO.  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Clarence Linwood ROLLINS   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>January 27, 1982                          |   | 2b. HOUR<br>9:50 <sup>AM</sup>               |
| 3. SEX<br>Male  | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Apr. 3, 1903  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>78 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                                       |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Maryland General Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Investigator |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>B&O RR  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY   | 13c. CITY OR TOWN<br>Baltimore   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>6201 Loch Raven Blvd. |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Clarence L. Rollins   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Lillian Deshield                |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>215 05 3470  |  | 17. INFORMANT ADDRESS<br>Mrs. Dorothy M. Rollins Same   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Severe diffuse bronchopneumonia with<br>5559<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br><del>XXXXXXXXXXXXXXXXXXXX</del><br>(b) micro-abscess formation of the LUNGS.<br>(c) DUE TO, OR AS A CONSEQUENCE OF<br>CROHNS DISEASE  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from November 13, 1981, to January 27, 1982, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on January 27, 1982, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> view the body after death. |  |   |  |   |  |
| 22b. SIGNATURE<br>Mohammed Aslam M.D.<br>DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>   |  |   |  | 22c. DATE SIGNED<br>1/27/82   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Mohammad Aslam, M.D.   |  |   |  | 22e. ADDRESS<br>c/o Maryland General Hospital   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>1/29/82  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto., Md.   |  |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Henry W. Jenkins & Sons Co.<br>4905 York Road Balto., Md. 21212   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 28 1982  |  |
|   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br>Frances Jean Nathan   |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO.   |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>Isabella (Isabelle)</b>   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>01/04/82</b>  |  |   |  |
| 3. SEX<br><b>Female</b>  |  |   |  | 2b. HOUR<br><b>9:00a</b>   |  |   |  |
| 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>12 26 03</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b>   |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Johns Hopkins Hospital</b> |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>John Griffin</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Ida M. Bose</b>  |  | 13e. STREET ADDRESS<br><b>1524 N. Bond St.</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>218-07-2734</b>  |  | 17. INFORMANT ADDRESS<br><b>Ernest Rollins 616 Radnor Ave.</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:<br><b>0389</b> IMMEDIATE CAUSE (a) <b>cardiopulmonary</b> died <b>1/4/82 - 9A.</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Sepsis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>1131 19 82</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>11/3</b> 19 <b>82</b> , to <b>1/4</b> 19 <b>82</b> , that (1) (we) lost saw the deceased alive on <b>1/3</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.                            |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>B. Herwaldt</b>   |  | DEGREE<br><b>MD</b>   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |  | 22c. DATE SIGNED<br><b>1/4/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>B. Herwaldt</b>  |  | 22e. ADDRESS<br><b>Halsted 4</b>  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>1/8/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MD. NAT. MEM. PK.</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Laurel MD</b>   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Wm. C. March F/H, Inc.</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR AND REGISTRAR'S SIGNATURE<br><b>JAN 6 1982</b>   |  |   |  |
| ADDRESS<br><b>1101 E. North Ave.</b>   |  |   |  |  |  |   |  |



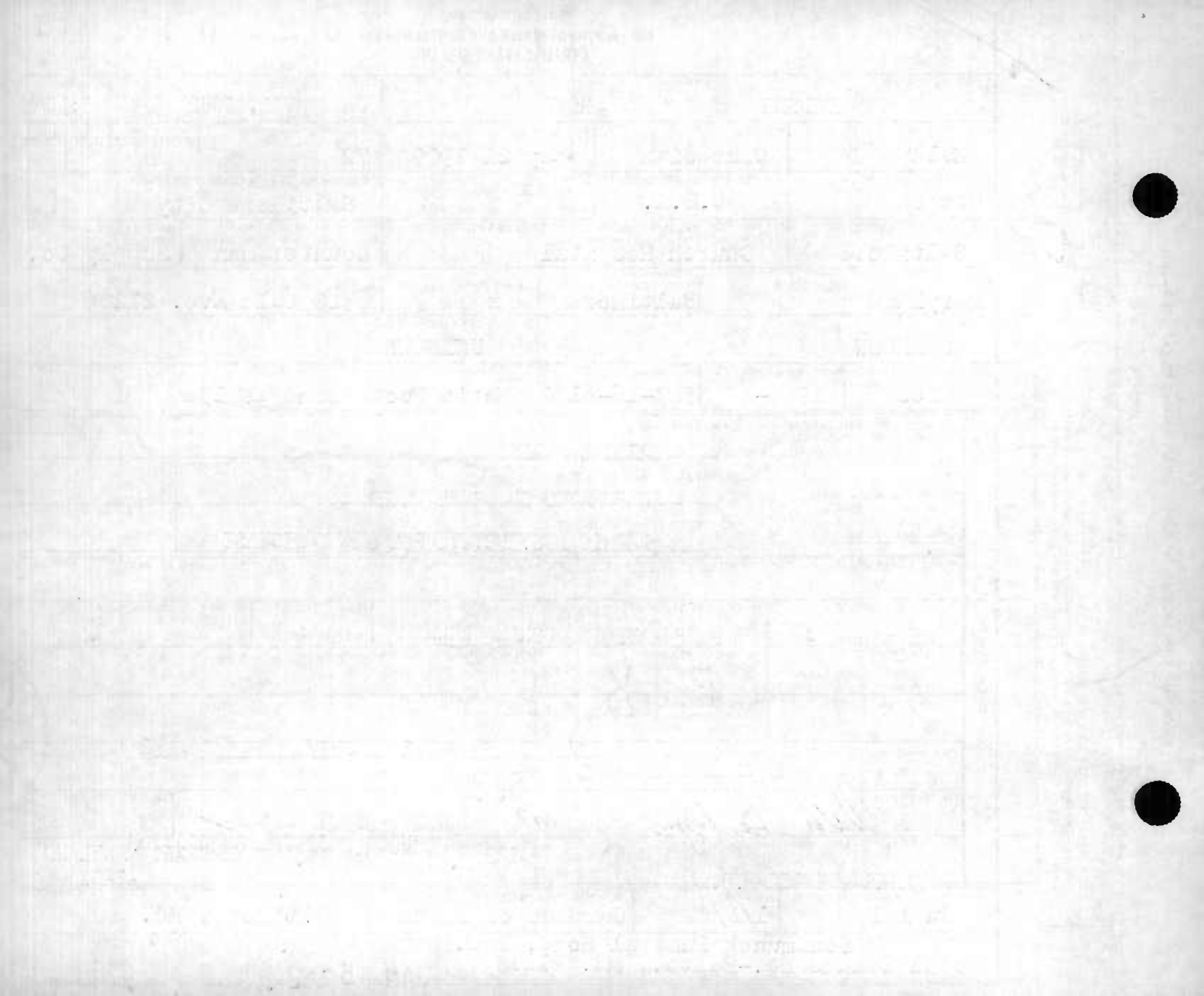


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |   |  | 8 2 0 1 4 3 8  |  |  |  |
|---|--|---|--|---|--|--|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  |   |  |  |  |   |  | REG. NO.   |  |  |  |
| 1. DECEASED NAME<br>(FIRST OR PRINT)  |  |   |  |   |  | 2a. DATE OF DEATH  |  | MONTH DAY YEAR  |  | 2b. HOUR   |  |  |  |
| EVERETT W ROOT  |  |   |  |   |  | JANUARY 1, 1982  |  |   |  | 5:15AM   |  |  |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR   |  | IF UNDER 24 HRS  |  |  |  |
| Male  |  | Caucasian   |  | May 21 1909   |  | 72   |  | MONTHS DAYS   |  | HOURS MIN.   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |   |  |  |  |  |  |
| Oregon  |  | U.S.A.  |  |   |  | Baltimore City MD  |  |   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)               |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |  |  |
| Baltimore   |  | Church Hospital   |  |   |  | Counter man  |  | Supply Co.  |  |  |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |   |  |  |  |   |  |  |  |  |  |
| 13a. STATE  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?   |  | 13e. STREET ADDRESS   |  |  |  |  |  |
| Maryland  |  |   |  | Baltimore   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 520 Dale Ave. 21206   |  |  |  |  |  |
| 14. FATHER'S NAME   |  |   |  |   |  | 15. MOTHER'S MAIDEN NAME   |  |   |  |  |  |  |  |
| UNKNOWN   |  |   |  |   |  | UNKNOWN  |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE IT - 9 DIGITS)  |  | 17. INFORMANT  |  | ADDRESS   |  |  |  |  |  |
| Yes   |  |   |  | WW II   |  | Marie Root   |  | Same as 13e   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>PERFORATED DUODENAL ULCER</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) |  |   |  |   |  |  |  |   |  |  |  |  |  |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |   |  |   |  |  |  |   |  |  |  |  |  |
| MEDICAL CERTIFICATION   |  |   |  |   |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |  |
| DECEMBER 9,   |  |   |  | PERFORATED DUODENAL ULCER   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/4, 19 81, to 1/1, 19 82, that (I) (we) last saw the deceased alive on 1/1, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE  |  |   |  |   |  | DEGREE   |  | 22c. DATE SIGNED  |  |  |  |  |  |
| Walter Bender M.D.  |  |   |  |   |  | MD   |  |   |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   |  |   |  | 22e. ADDRESS   |  |   |  |  |  |  |  |
| WALTER BENDER M.D.  |  |   |  |   |  | 100 N. BROADWAY ST. BALTIMORE, MARYLAND 21231                                  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  |   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |  |  |  |  |  |
| Burial  |  |   |  | 1/4/82  |  | Gardens of Faith   |  | Baltimore, Md.  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |  |  |
| Schimunek Funeral Home, Inc.<br>3331 Brehms La.-Balto., Md. 21213   |  |   |  |   |  | JAN 5 1982   |  |   |  |  |  |  |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 4 3 9

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |  |  |  |  |   |  |
|---|--|--|--|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>SAMUEL ROSE</b>  |  |  | 2b. DATE OF DEATH MONTH <b>1</b> DAY <b>29</b> YEAR <b>82</b>    |  |  | 2c. HOUR <b>6:30 PM</b>  |  |   |  |
| 3. SEX <b>MALE</b>  |  | 4. RACE <b>WHITE</b>   |  | 5. DATE OF BIRTH MONTH <b>04</b> DAY <b>17</b> YEAR <b>95</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b> YRS.   |  | 7. IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>RUSSIA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.                               |  |   |  |
| 10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SINAI HOSPITAL</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>MERCHANT</b>                |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>RETAIL</b>   |  |
| 13a. STATE <b>MARYLAND</b>  |  | 13b. COUNTY <b>BALTO</b>   |  | 13c. CITY OR TOWN <b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <b>#21215</b><br><b>13 COBBLESTONE CT., APT. 1A</b>   |  |
| 14. FATHER'S NAME FIRST <b>NATHAN</b> MIDDLE <b>ROSE</b> LAST <b>ROSE</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST <b>BESSIE</b> MIDDLE <b>UNKNOWN</b> LAST <b>UNKNOWN</b>   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>   |  | 16b. SOCIAL SECURITY NO. <b>217-12-5310</b>  |  | 17. INFORMANT <b>HAROLD ROSE</b> ADDRESS <b>301 S. ROLLING RD. #21228</b>  |  | 17b. ADDRESS <b>XXXXXXXXXXXX</b>   |  | 17c. ADDRESS <b>XXXXXXXXXXXX</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4100 Acute mtf</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Senility</b> |  |  |  |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION <b>1/29/82</b>   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Senility</b> |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>12 P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that (I) this hospital attended the deceased from <b>12/29/81</b> to <b>1/29/82</b> , that (I) <b>two</b> lost saw the deceased alive on <b>1/29/82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |  |  |   |  |
| 22b. SIGNATURE <b>H. Halay MD</b>   |  |  |  | 22c. DEGREE <b>MD</b>  |  |  |  | 22d. DATES SIGNED <b>1/29/82</b>  |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) <b>J. G. ABAY</b>   |  |  |  | 22f. ADDRESS <b>A. HOB.</b>  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>   |  | 23b. DATE <b>2-1-82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>LUBAWITZ NUSACH ARI</b>  |  | 23d. LOCATION CITY OR TOWN <b>ROSEDALE BALTO.</b> COUNTY <b>BALTO.</b> STATE <b>MD</b>       |  |   |  |
| 24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., INC.</b><br>NAME <b>6010 REISTERSTOWN RD., BALTO., MD 21215</b>   |  |  |  | 25. DATE REC'D. BY REGISTRAR <b>FEB 2 1982</b> REGISTRAR'S SIGNATURE <b>Frances San Martin</b>   |  |  |  |   |  |

(2)

DATE

BY

TIME

PLACE

RECEIVED  
FBI  
JAN 10 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of it.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 2 0 1 4 4 0

|   |  |  |   |   |  |  |   |  |  |  |
|---|--|--|---|---|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>LOUIS LEE ROSENBERG</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 25 82</b>                         |   |  | 2b. HOUR<br><b>4:45 AM</b>   |   |  |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 27 1913</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>88</b> YRS   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. <b>BALTIMORE CITY OR COUNTY OF DEATH</b><br><b>BALTIMORE CITY</b> MD  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT INSURE FACILITY, GIVE STREET ADDRESS)<br><b>LEVINDALE HEBREW HOME</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>MERCHANT</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>RETAIL</b>   |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br><b>MARYLAND</b>   |  |  |   |   | 13b. COUNTY<br><b>BALTIMORE</b>  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                                   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ALBERT ROSENBERG</b>   |  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>REBECCA GOLDSTEIN</b>                          |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>226-44-9179</b> |   | 17. INFORMANT<br>ADDRESS<br><b>MRS. SARAH ROSENBERG 3601 CLARKS LA., APT. 201 BALTO., MD 21215</b> |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line or (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute renal failure</b><br>4100<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cardiac failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Myocardial infarction</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 wks.</b><br><b>2 wks.</b> |  |  |   |   |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |   |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                              |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>                  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)        |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/25</b> 19 <b>82</b> to <b>1/25</b> 19 <b>82</b> , that (I) (we) lost above, (I) (we) (did) (did not) view the body after death.   |  |  |   |   |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Steven A. Levenson</b>   |  |  | DEGREE<br><b>M.D.</b>   |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>1/25/82</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>STEVEN A. LEVENSON, M.D.</b>  |  |  |   |   | 22e. ADDRESS<br><b>LEVINDALE - BALTO., MD</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  |  | 23b. DATE<br><b>JAN. 27, 1982</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ANSHE EMUNAH</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b> |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b><br>ADDRESS<br><b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>   |  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 2 1982</b>   |  |   |  |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 48 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT) **FRIEDA** MIDDLE **Rosensweig** LAST **Rosensweig**

2a. DATE OF DEATH MONTH **Jan** DAY **23** YEAR **1982** 2b. HOUR **10** MIN **40**

3. SEX **FEMALE** 4. RACE **WHITE** 5. DATE OF BIRTH MONTH **9** DAY **28** YEAR **1889** 6. AGE (IN YEARS LAST BIRTHDAY) **92** 7. IF UNDER 1 YEAR MONTHS **0** DAYS **0** 8. IF UNDER 24 HRS. HOURS **0** MIN. **0**

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) **Poland** 7b. CITIZEN OF WHAT COUNTRY? **USA** 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ 9. BALTIMORE CITY OR COUNTY OF DEATH **BALTIMORE CITY** MD.

10. CITY OR TOWN OF DEATH **Baltimore** 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) **Levinthal** 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) **HOUSEWIFE** 12b. KIND OF BUSINESS OR INDUSTRY **AT HOME**

13a. STATE **MARYLAND** 13b. COUNTY **BALTIMORE** 13c. CITY OR TOWN **BALTIMORE** 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ 13e. STREET ADDRESS **3606 SEQUOIA AVE. #21215**

14. FATHER'S NAME FIRST **BEN** MIDDLE **FRIED** LAST **FRIED** 15. MOTHER'S MAIDEN NAME FIRST **GAIL** MIDDLE **UNKNOWN** LAST **UNKNOWN**

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) **NO** 16b. SOCIAL SECURITY NO. **099-18-5293** 17. INFORMANT **MRS. ANNA THEA** APT. **E** 3616 FORDS LA. BALTO., MD 21215

18. CAUSE OF DEATH (Enter only one cause per line) (General) **General Infection and Debilitation.** PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) **2639** DUE TO, OR AS A CONSEQUENCE OF (b) **Multiple Systemic Failure** DUE TO, OR AS A CONSEQUENCE OF (c) **2639** APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH **1 year**

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 19c. AUTOPSY? YES ☐ NO ☐ 19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. **19** 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21a. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21c. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (1) (this hospital) attended the deceased from **1/23/82** to **1/23/82**, that (we) lost saw the deceased alive on **1/23/82** and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) did not view the body after death.

22b. SIGNATURE **N. D. LIST** DEGREE **M.D.** ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 22c. DATE SIGNED **1/23/82**

22d. PHYSICIAN'S NAME (TYPE OR PRINT) **N. D. LIST** 22e. ADDRESS **Greening & Balaban**

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) **BURIAL** 23b. DATE **JAN. 25, 1982** 23c. NAME OF CEMETERY OR CREMATORY **SHAAREI ZION** 23d. LOCATION CITY OR TOWN COUNTY STATE **ROSEDALE BALTO. MD**

24. FUNERAL DIRECTOR **SOL LEVINSON & BROS., INC.** ADDRESS **6010 REISTERSTOWN RD. BALTO., MD 21215** 25a. DATE REC'D. BY REGISTRAR **JAN 27 1982** 25b. REGISTRAR'S SIGNATURE **James J. Nathan**



20

Common from the 1st collection  
Multiple 2nd collection

1st collection  
2nd collection  
3rd collection  
4th collection  
5th collection  
6th collection  
7th collection  
8th collection  
9th collection  
10th collection

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 8 2 0 1 4 4 2   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>CARL SYDNEY ROSS</b>   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>1-1-82</b>   |  |  |  |
| 3. SEX <b>M</b>   |  |  |  | 4. RACE <b>W</b>  |  | 2b. HOUR<br><b>2:30 AM</b>   |  |
| 5. DATE OF BIRTH MONTH DAY YEAR<br><b>7-9-87</b>  |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>94</b>  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>OWNER</b>   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. AGNES HOSPITAL</b>                         |  |  |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>TAVERN</b>  |  |  |  | 13a. STREET ADDRESS<br><b>3833 WILKENS AVENUE, 21229</b>  |  |  |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>---</b>  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>FRANK ROSS</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>UNKNOWN</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>212-34-9541</b>   |  | 17. INFORMANT ADDRESS<br><b>DELSIE V. KATZ 3833 WILKENS AVENUE, 21229</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>- CARDIORESPIRATORY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>- BILATERAL PNEUMONITIS</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10 hours</b><br><b>11 days</b> |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR <b>2:30</b> P.M. MONTH <b>1</b> DAY <b>1</b> YEAR <b>1982</b> |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>DEC 28</b> , 19 <b>81</b> , to <b>JAN 1</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>JAN -1</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Carlos Gouantes MD</b>   |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>1/1/82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CARLOS GOUANES MD</b>   |  | 22e. ADDRESS<br><b>St. Agnes Hosp</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>01-04-82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LOUDON PARK</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>BALTIMORE CITY MARYLAND</b>  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>HUBBARD FUNERAL HOME, INC.</b>  |  | ADDRESS<br><b>4107 WILKENS AVE.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 4 1982</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles J. Nathan</b>   |  |



TO THE DIRECTOR  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C.  
FROM THE  
SAC, NEW YORK  
SUBJECT: [Illegible]  
[Illegible text follows, appearing to be a memorandum or report body.]

Very truly yours,  
[Illegible Signature]  
Special Agent in Charge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 8 2 0 1 4 4 3  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  | REG. NO.   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  |  | 2a. DATE OF DEATH  |  |  |  |
| FIRST MIDDLE LAST<br><b>Herman E. Ross</b>  |  |  |  | MONTH DAY YEAR<br><b>January 11, 1982</b>  |  |  |  |
| 3. SEX  |  |  |  | 2b. HOUR   |  |  |  |
| <b>Male</b>   |  |  |  | <b>4:30 P.M.</b>   |  |  |  |
| 4. RACE   |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR  |  |
| <b>Caucasian</b>  |  | MONTH DAY YEAR<br><b>12 15 1918</b>  |  | <b>63</b> YRS.   |  | MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |  |  |
| <b>Maryland</b>   |  | <b>U.S.A.</b>  |  | <b>Baltimore City</b> MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| <b>Baltimore</b>  |  | <b>632 S. Ellwood Avenue</b>   |  | <b>retired-City of Balto.</b>  |  |  |  |
| 13a. STATE  |  |  |  | 13b. CITY OR TOWN  |  |  |  |
| <b>Md.</b>  |  |  |  | <b>Balto.</b>  |  |  |  |
| 14. FATHER'S NAME   |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |
| FIRST MIDDLE LAST<br><b>Louis Ross</b>  |  |  |  | FIRST MIDDLE LAST<br><b>Nancy D'Alesandro</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)   |  |  |  | 16b. SOCIAL SECURITY NO.   |  |  |  |
| <b>Yes WWII</b>   |  |  |  | <b>219-03-1333</b>   |  |  |  |
| 17. INFORMANT   |  |  |  | ADDRESS  |  |  |  |
| <b>Mrs. Rose Ross</b>   |  |  |  | <b>632 S. Ellwood Ave.</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:   |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (a) <b>Cardio Respiratory Arrest</b>  |  |  |  |  |  |  |  |
| 4029 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hypertensive Cardiovascular Disease</b> 5 years  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  |
|   |  |  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
|   |  |  |  | P.M. 19  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |
|   |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Feb. 13</b> 19 <b>76</b> to <b>Nov. 19</b> 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>Nov. 19</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE  |  |  |  | DEGREE   |  | 22c. DATE SIGNED   |  |
| <b>Edmund G. Paulino M.D.</b>   |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | <b>1/13/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | 22e. ADDRESS   |  |  |  |
| <b>H.B. PAULINO</b>   |  |  |  | <b>101 West Read St. Balt. Md. 21201</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |
| <b>Entombment</b>   |  | <b>1/14/82</b>   |  | <b>Oaklawn Cem.</b>  |  | <b>Baltimore, Md.</b>  |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS   |  |  |  | 25a. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE  |  |  |  |
| <b>Zannino Funeral Home, 263 S. Conkling St.</b>  |  |  |  | <b>JAN 14 1982 James J. Martin</b>   |  |  |  |

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

January 11, 1965

Page 2

Letter

63

12-12-1964

Memorandum

File

Subject

W.B.A.

Reference

Retired-City of Baltimore

635 E. Alwood Avenue

Baltimore

635 E. Alwood Ave.

X

Baltimore

Id.

11/11/64

Handy

Room

Room

635 E. Alwood Ave., Baltimore, Md.

SI-100-1000

File

Id.

Baltimore, Md.

Calvin C. ...

1/11/65

Memorandum

Memorandum for the Director, FBI, dated 1/11/65, at Baltimore, Md.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the attending physician.



| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 8 2 0 1 4 4 4<br>4 15 AM   |   |
|---|--|---|--|--|---|
| 1. FOR STATE REGISTRAR  |  |   |  | REG. NO.   |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ROBERT S. ROSS</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 12 1/82</b>          |  | 2b. HOUR<br><b>5:15 AM</b>  |
| 3. SEX<br><b>M</b>  | 4. RACE<br><b>B</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 25 08</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b><br>YRS. MONTHS DAYS HOURS MIN.    |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VIRGINIA</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD               |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNIVERSITY OF MD</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. STATE<br><b>MD</b>   |  |   | 13b. CITY OR TOWN<br><b>BALTO CITY</b>                           | 13c. STREET ADDRESS<br><b>941 W. Fayette St.</b>                               |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Robert Ross</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mattie ?</b> |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>216-74-9895</b>  |  | 17. INFORMANT ADDRESS<br><b>Josephine McCray 949 W. Fayette St.</b>            |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>0389</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>CARDIAC ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>ACIDOSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF (d) <b>PROBABLE SEPSIS</b>  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 DAYS</b><br><b>1 DAY</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>CARCINOMA OF THE LUNG</b>  |  |   |  |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1980</b> , 19 <b>81</b> , to <b>1/21</b> , 19 <b>81</b> , that (I) (we) lost<br>saw the deceased alive on <b>1/20</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above (I) (we) (did not) view the body after death. |  |   |  |  |   |
| 22b. SIGNATURE<br><b>Scott T. Maurer MD</b>   |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>1/21/81</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SCOTT T MAURER MD</b>   |  | 22e. ADDRESS<br><b>UNIVERSITY OF MD HOSPITAL</b>  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>  |  | 23b. DATE<br><b>1/25/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Calvary Cem.</b>                  |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Anne Arundel Co. MD</b>  |  | 23e. DATE OF BURIAL<br><b>JAN 25 1982</b>   |  |  |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H, Inc. 1101 E. North Ave.</b>  |  | 25a. DATE OF DEATH<br><b>JAN 25 1982</b>  |  |  |   |



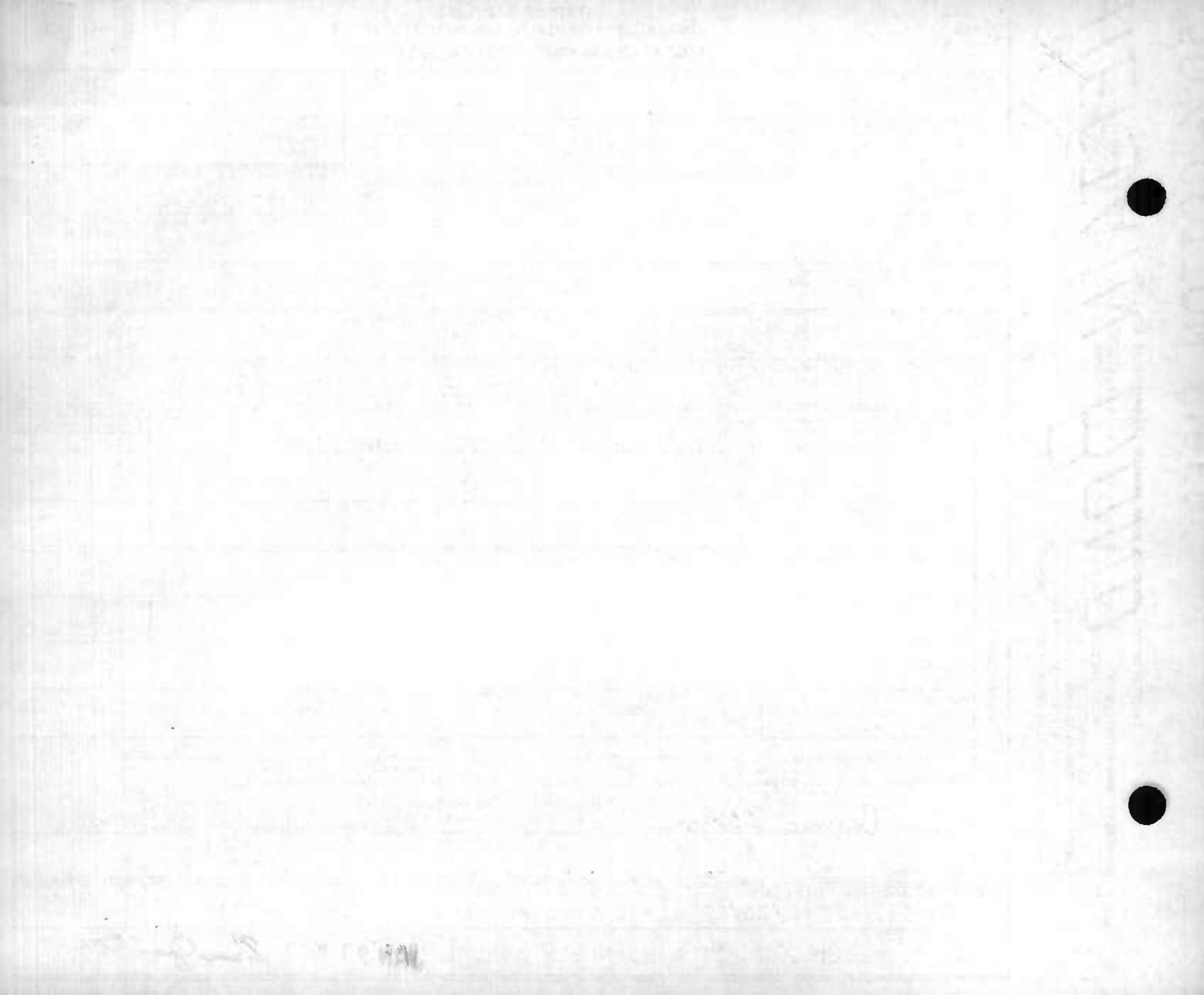
(M)

F  
191

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| FOR<br>1- STATE<br>REGISTRAR  |  |                  |  |   |  |  |  |   |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                    |  |   |  |  |  |   |  |  |  | REG. NO.                 |  |
|---|--|------------------|--|---|--|--|--|---|--|---|--|---|--|--|--|---|--|--|--|--------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Thomas B. Ross   |  |                  |  |   |  |  |  |   |  | 2b. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br>1 20 19 82 |  |   |  |  |  |   |  |  |  | 2d. HOUR<br>3:46<br>A.M. |  |
| 3. SEX<br>Male  |  | 4. RACE<br>Black |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11 27 13 68   |  | 6. AGE (IN YEARS<br>LAST BIRTHDAY)<br>YRS<br>68            |  | IF UNDER 1 YR.<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.  |  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>1 20 19 82  |  | 2d. HOUR<br>3:46<br>A.M.                     |  |   |  |  |  |                          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>S.C.   |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                                     |  |  |  |   |  |  |  |                          |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Lutheran Hospital |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |   |  |  |  |                          |  |
| 13a. STATE<br>MD  |  |                  |  | 13b. COUNTY   |  |  |  | 13c. CITY OR TOWN<br>Baltimore  |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  | 13e. STREET ADDRESS<br>814 Bentalou St.             |  |  |  |                          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Clarence Ross   |  |                  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Alma Cook |  |   |  |   |  |   |  |  |  |   |  |  |  |                          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>Yes  |  |                  |  | 16b. SOCIAL SECURITY NO.<br>214-03-3468   |  |  |  | 17. INFORMANT<br>Gloria Ross  |  |   |  | ADDRESS<br>814 Bentalou St.   |  |  |  |   |  |  |  |                          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>4292 IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |                  |  |   |  |  |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |  |  |                          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |                  |  |   |  |  |  |   |  |   |  |   |  |  |  |   |  |  |  |                          |  |
| 19a. DATE OF OPERATION  |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |  |  |  |   |  |  |  |                          |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |   |  |  |  |   |  |  |  |                          |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |  |  |   |  |  |  |                          |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                  |  |   |  |  |  |   |  |   |  |   |  |  |  |   |  |  |  |                          |  |
| ACTUAL SIGNATURE<br><u>Virginia L. Dolan</u>  |  |                  |  | TITLE (SPECIFY)<br>M.D. Assistant   |  |  |  | MEDICAL EXAMINER  |  |   |  | DATE SIGNED<br>1-20-82  |  |  |  |   |  |  |  |                          |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Virginia L. Dolan, M.D.   |  |                  |  | ADDRESS<br>111 Penn Street  |  |  |  |   |  |   |  |   |  |  |  |   |  |  |  |                          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |                  |  | 23b. DATE<br>1/25/82  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Md. Veteran Cem.  |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Crownsville MD                                    |  |  |  |   |  |  |  |                          |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H  |  |                  |  |   |  |  |  |   |  | ADDRESS<br>1101 E. North Ave.   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 21 1982 |  | 25b. REGISTRAR'S SIGNATURE<br><u>Thane J. North</u> |  |  |  |                          |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         |                              |   |  |                  |   |  |   |                                   | 2a. DATE KNOWN OF DEATH      |  | 2b. HOUR  |  |
|--|---------|------------------------------|---|--|------------------|---|--|---|-----------------------------------|------------------------------|--|-----------|--|
| FIRST MIDDLE LAST<br>KEVIN M ROY   |         |                              |   |  |                  |   |  |   |                                   | MONTH DAY YEAR<br>1 27 19 82 |  | M<br>9:22 |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH             | 6. AGE (IN YEARS)   | IF UNDER 1 YR.   | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD  |  | 7d. HOUR  |                                   |                              |  |           |  |
| male   | negro   | MONTH DAY YEAR<br>9 21 64    | 17 YRS.   | MONTHS DAYS  | HOURS MIN.       | MONTH DAY YEAR<br>1 27 19 82  |  | P M<br>9:22   |                                   |                              |  |           |  |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY? |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |   |                                   |                              |  |           |  |
| MD   |         | USA                          |   |  |                  | Baltimore City MD.  |  |   |                                   |                              |  |           |  |
| 10. CITY OR TOWN OF DEATH  |         |                              | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |  |   | 12b. KIND OF BUSINESS OR INDUSTRY |                              |  |           |  |
| Baltimore  |         |                              | 770 W. Saratoga St. (elevator)  |  |                  |   |  |   |                                   |                              |  |           |  |
| 13a. STATE   |         |                              |   | 13b. COUNTY  |                  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |                                   | 13e. STREET ADDRESS          |  |           |  |
| MD   |         |                              |   |  |                  | Baltimore   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                   | 915 Pennsylvania Ave.        |  |           |  |
| 14. FATHER'S NAME  |         |                              |   | 15. MOTHER'S MAIDEN NAME   |                  |   |  |   |                                   |                              |  |           |  |
| FIRST MIDDLE LAST<br>Jasper Roy  |         |                              |   | FIRST MIDDLE LAST<br>Hazel Wallace   |                  |   |  |   |                                   |                              |  |           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |         |                              |   | 16b. SOCIAL SECURITY NO.   |                  | 17. INFORMANT ADDRESS   |  |   |                                   |                              |  |           |  |
| No   |         |                              |   | N/A  |                  | Hazel Wallace 915 Pennsylvania Ave.   |  |   |                                   |                              |  |           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         |                              |   |  |                  |   |  |   |                                   |                              |  |           |  |
| PART I DEATH WAS CAUSED BY:  |         |                              |   |  |                  |   |  |   |                                   |                              |  |           |  |
| IMMEDIATE CAUSE (a) <u>Gunshot wounds to head (unspecified weapon)</u>   |         |                              |   |  |                  |   |  |   |                                   |                              |  |           |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |                              |   |  |                  |   |  |   |                                   |                              |  |           |  |
| (b) _____  |         |                              |   |  |                  |   |  |   |                                   |                              |  |           |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |                              |   |  |                  |   |  |   |                                   |                              |  |           |  |
| (c) _____  |         |                              |   |  |                  |   |  |   |                                   |                              |  |           |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |         |                              |   |  |                  |   |  |   |                                   |                              |  |           |  |
| 19a. DATE OF OPERATION   |         |                              |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |                  |   |  | 20. AUTOPSY?  |                                   |                              |  |           |  |
|  |         |                              |   |  |                  |   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                   |                              |  |           |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         |                              |   | 21b. TIME OF INJURY  |                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |   |                                   |                              |  |           |  |
|  |         |                              |   | HOUR MONTH DAY YEAR<br>9:15 P.M. 1-27-1982   |                  | Subject was shot.   |  |   |                                   |                              |  |           |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>   |         |                              |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |                  | 21f. LOCATION   |  | CITY OR TOWN  |                                   | COUNTY STATE                 |  |           |  |
|  |         |                              |   | elevator   |                  | 770 W. Saratoga St., Balto.   |  | Baltimore   |                                   | Md.                          |  |           |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . |         |                              |   |  |                  |   |  |   |                                   |                              |  |           |  |
| ACTUAL SIGNATURE   |         |                              |   | TITLE (SPECIFY)  |                  |   |  | DATE SIGNED   |                                   |                              |  |           |  |
|  |         |                              |   | M.D. Assistant MEDICAL EXAMINER  |                  |   |  | 1-28-82   |                                   |                              |  |           |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |         |                              |   | ADDRESS  |                  |   |  |   |                                   |                              |  |           |  |
| Ann M. Dixon, M.D.   |         |                              |   | 111 Penn St.   |                  |   |  |   |                                   |                              |  |           |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |         |                              |   | 23b. DATE  |                  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION   |                                   | COUNTY STATE                 |  |           |  |
| Burial   |         |                              |   | 2/1/82   |                  | King Mem. Park  |  | Baltimore   |                                   | Co. MD                       |  |           |  |
| 24. FUNERAL DIRECTOR   |         |                              |   |  |                  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |                                   |                              |  |           |  |
| NAME<br>Wm. C. March F/H   |         |                              |   |  |                  | ADDRESS<br>1101 E. North Ave.   |  | JAN 29 1982   |                                   |                              |  |           |  |

2000 25 MAY 1980

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 2 0 1 4 4 7  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  | REG. NO.   |  |  |  |
| 1. DECEASED NAME (Type or print)<br>FIRST MIDDLE LAST<br>Willard J. Roy   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>1-24-82  |  |  |  |
| 3. SEX<br>Male  |  |   |  | 7b. HOUR<br>6:45 A.M.  |  |  |  |
| 4. RACE<br>Black  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>8 12 1918  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>63  |  | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>VA  |  |
| 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore city MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>John W. Deaton Med CTR.                        |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>Md  |  |   |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Baltimore   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Willie Roy   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Emma Braxton  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) NO  |  |  |  |
| 16b. SOCIAL SECURITY NO.<br>225-20-5788   |  | 17. INFORMANT ADDRESS<br>Willard J. Roy Jr. 3917 Dolfield Ave.  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Bronchogenic Ca of Lung<br>DUE TO, OR AS A CONSEQUENCE OF (b) C.U.A.<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 years<br>2 years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/8 1981 to 1/23 1982, that (I) (we) last saw the deceased alive on 1/23 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br>Paul Schonfeld MD   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>1/24/82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Paul Schonfeld MD  |  |   |  | 22e. ADDRESS<br>407 Cien Highway   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(Type or print)<br>Burial  |  | 23b. DATE<br>1/28/82  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Auburn Cem.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore MD   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H 1101 E. North Ave.   |  |   |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br>JAN 27 1982  |  |  |  |

Handwritten header text at the top of the page, possibly a date or reference number.



Main body of handwritten text, appearing as several lines of cursive script across the page.

Handwritten text at the bottom left corner of the page.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at (410) 338-1234.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |  |  |   |   |  | 8 2 0 1 4 4 8 |  |
|---|--|---|--|--|--|--|---|---|--|---------------|--|
| FOR<br>STATE<br>REGISTRAR   |  |   | REG. NO.   |  |  |  |   |   |  |               |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>ROMAN ROZPEDOWSKI</b>   |  |   | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>1-11-82</b>               |  |  | 2b HOUR<br><b>9:00 A.M.</b>  |   |   |  |               |  |
| 3 SEX<br><b>male</b>  |  | 4 RACE<br><b>Caucasian</b>  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12-14-06</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>75 yrs.</b>   |   | 7 IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>75 yrs.</b>   |  |               |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Poland</b>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. City</b> MD.  |   |   |  |               |  |
| 10 CITY OR TOWN OF DEATH<br><b>Balto.</b>   |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>4135 Marx Ave.</b> |  |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Seaman</b>   |   | 12b KIND OF BUSINESS OR INDUSTRY<br><b>Seafarers Int Union</b>  |  |               |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b STATE<br><b>Md.</b>  |  | 13b COUNTY<br><b>Balto.</b>   |  | 13c CITY OR TOWN<br><b>Balto.</b>  |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 13e STREET ADDRESS<br><b>4135 Marx Avenue 21206</b>   |  |               |  |
| 14 FATHER'S NAME<br>(TYPE OR PRINT) <b>Unknown</b>  |  |   | 15 MOTHER'S MAIDEN NAME<br>(TYPE OR PRINT) <b>Unknown</b>          |  |  | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>no</b>  |   |   |  |               |  |
| 16b SOCIAL SECURITY NO.<br><b>217-16-3522</b>   |  |   | 17 INFORMANT<br><b>Victoria Rozpedowski</b>                        |  |  | 17 ADDRESS<br><b>21206 4135 Marx Ave.</b>  |   |   |  |               |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>metastatic adenocarcinoma of lungs</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>1629</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 1/2 minutes</b><br><b>~ 1 yr</b> |  |   |  |  |  |  |   |   |  |               |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |  |  |  |   |   |  |               |  |
| 19a DATE OF OPERATION   |  |   | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |               |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19          |  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   | 21d LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |               |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e PLACE OF INJURY<br>(AT HOME STREET FACTORY, OFFICE, FARM ETC.) |  |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   | 21g LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |               |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>MAY</b> 19 <b>81</b> , to <b>DEC</b> 19 <b>81</b> , that (I) (we) lost saw the deceased alive on <b>DEC 215</b> 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |  |   |   |  |               |  |
| 22b SIGNATURE<br><b>Gary Gordon</b>   |  |   | DEGREE<br><b>MD</b>  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c DATE SIGNED<br><b>11/2/82</b>   |  |               |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Gary Gordon</b>  |  |   | 22e ADDRESS<br><b>Johns Hopkins Hospital</b>                       |  |  |  |   |   |  |               |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |   | 23b DATE<br><b>1-14-82</b>   |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer Cem.</b> |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto., Md.</b> |   |  |               |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Schimunek Funeral Home, Inc.</b><br><b>3331 Brehms Lane 21213</b>   |  |   |  |  |  | 25a DATE RECD BY REG. MAR 75<br><b>JAN 12 1982</b>   |   | 25b REGISTRAR'S SIGNATURE<br><b>Thom J. [Signature]</b>   |  |               |  |



*[Faint, illegible handwritten text at the bottom left corner]*

BP

DHMH-17  
(VR A15 ME (5))  
15M 2/80

Items #10a-22a Film G565 3/5/82 re STATE OF MARYLAND  
2 · 0 · 1 · 4 · 4 · 9

FOR  
1- STATE  
REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|   |                  |  |   |   |   |  |   |   |                            |
|---|------------------|--|---|---|---|--|---|---|----------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Nelson W. Ruby   |                  |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED<br>MONTH DAY YEAR<br>1 29 1982 |   |   | 2b. HOUR<br>M<br>M   |   |   |                            |
| 3. SEX<br>Male  | 4. RACE<br>White | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Jan. 27, 1944  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>38 YRS.                       | IF UNDER 1 YR.<br>MONTHS DAYS   | IF UNDER 24 HRS.<br>HOURS MIN.  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>1 29 1982                  |   |   | 2d. HOUR<br>M<br>11:24 P M |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.              |   |   |                            |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>2644 Maryland Avenue |   |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Laborer |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Construction |                            |
| 13a. STATE<br>Maryland  |                  | 13b. COUNTY<br>-   | 13c. CITY OR TOWN<br>Baltimore                                      |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>2644 Maryland Avenue                              |   |   |                            |
| 14. FATHER'S NAME<br>FIRST LAST<br>Grayson B. Ruby  |                  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Marie S. Yokel   |   |  |   |   |                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>no   |                  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>214 44 9190   |   | 17. INFORMANT ADDRESS<br>Melvin T. Ruby 5627 Mayview Ave 21206  |   |  |   |   |                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute ethanol intoxication &amp; Fatty liver</u><br>5710<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH    |                  |  |   |   |   |  |   |   |                            |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |                  |  |   |   |   |  |   |   |                            |
| 19a. DATE OF OPERATION  |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |   |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |                            |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |  |   |   |                            |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |   |   |                            |
| 22a. I certify that I took charge of the remains described above, held as:<br>death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |                  |  |   |   |   |  |   |   |                            |
| ACTUAL SIGNATURE<br>EXAMINER'S NAME (TYPE OR PRINT)<br>Thomas D. Smith, M.D.  |                  | TITLE (SPECIFY)<br>M.D. Deputy Chief MEDICAL EXAMINER  |   |   |   | DATE SIGNED<br>1/30/82   |   |   |                            |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation  |                  | 23b. DATE<br>2/ /82  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview Crematory  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Westview Balto., Co. Md.   |   |   |                            |
| 24. FUNERAL DIRECTOR<br>NAME<br>Burgee Funeral Home   |                  |  |   | ADDRESS<br>3631 Falls Road 21211  |   | 25a. DATE REC'D. BY REGISTRAR<br>FEB 9 1982                              |   | 25b. REGISTRAR'S SIGNATURE<br>Thomas D. Smith     |                            |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director. Page 3 should be retained by the funeral director. Page 4 should be retained by the funeral director.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 8 2 0 1 4 5 0  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1- FOR STATE REGISTRAR  |  |   |  | REG. NO.   |  |  |  |
| 1 DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Carroll Nicholas Rush   |  |   |  | 2a DATE OF DEATH MONTH DAY YEAR 2b HOUR<br>January 4, 1982 12 noon   |  |  |  |
| 3 SEX<br>male   |  | 4 RACE<br>white   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>July 3, 1928  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN.<br>53  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University of Maryland Hosp |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Laborer   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Maintenance   |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE<br>md. Anne Arundel Pasadena  |  |   |  | 13b. CITY OR TOWN<br>Pasadena  |  | 13c. STREET ADDRESS<br>7728 W. Shore Road  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Henry Charles Rush Sr.   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Annabelle Road   |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>yes   |  |   |  | 16b SOCIAL SECURITY NO.<br>1951-1953 217.24.8196   |  | 17. INFORMANT (Sister) ADDRESS<br>Mrs. Regina Dolan Balt., MD. 21227   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Gastrointestinal Hemorrhage</u><br>5713<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Hepatic Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Alcoholic Liver Disease</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>12 hrs<br>3 months |  |   |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><u>Sepsis.</u>   |  |   |  |  |  |  |  |
| 19a DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)  |  |  |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a I certify that (I) (this hospital) attended the deceased from 12/22, 1981 to 1/4, 1982, that (I) (we) last saw the deceased alive on 1/4, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |  |  |
| 22b SIGNATURE<br>K Kasser-Taub MD   |  |   |  | DEGREE   |  | 22c DATE SIGNED<br>1/4/82  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>K Kasser-Taub, MD   |  |   |  | 22e ADDRESS<br>U of Md Hospital, Baltimore md  |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>8 Jan. 82  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Glen Haven Mem.Pk.   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Glen Burnie, A.A., MD.  |  |
| 24 FUNERAL DIRECTOR NAME<br>Dawn F. Charley   |  |   |  | ADDRESS<br>Glen Burnie, MD.  |  | 25a DATE REC'D. BY REGISTRAR<br>JAN 7 1982   |  |
|   |  |   |  | 25b REGISTRAR'S SIGNATURE<br>James J. Nathan   |  |  |  |

1905

Items #18a-22a Film G565 3/1/82 re STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR  
1- STATE REGISTRAR

REG. NO. 2 0 1 4 5 1

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST  
CLARA RUSSELL

2a. DATE KNOWN OF DEATH MONTH DAY YEAR  
1-21-82 19

2b. HOUR  
1:42P

3. SEX female 4. RACE black 5. DATE OF BIRTH MONTH DAY YEAR  
Nov 13, 1957 24 YRS.

6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.

7c. DATE PRONOUNCED DEAD MONTH DAY YEAR  
1-21-82 19

7d. HOUR  
1:42P

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  
U.S.A.

7b. CITIZEN OF WHAT COUNTRY?  
U.S.A.

8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH  
Baltimore City MD.

10. CITY OR TOWN OF DEATH  
Baltimore

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  
Provident Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  
Baltimore City

12b. KIND OF BUSINESS OR INDUSTRY

13a. STATE MD 13b. COUNTY 13c. CITY OR TOWN Baltimore 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ 13e. STREET ADDRESS 2421 Etting St.

14. FATHER'S NAME FIRST MIDDLE LAST 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) 16b. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS  
Lillian Russell 2421 Etting St.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Seizure disorder 7803  
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.  
(b) DUE TO, OR AS A CONSEQUENCE OF  
(c) DUE TO, OR AS A CONSEQUENCE OF

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  
P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22. I certify that I took charge of the remains described above, held on Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Margarita A. Korell M.D. TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER DATE SIGNED 1-22-82

EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. ADDRESS 111 Penn Street

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION CITY OR TOWN COUNTY STATE

24. FUNERAL DIRECTOR NAME Wm C Brown Comm F/H ADDRESS 1206-08 W. North Ave. 25a. DATE REC'D. BY REGISTRAR FEB 1 1982 25b. REGISTRAR'S SIGNATURE Frances Jean Nathan

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD, 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (1))  
15M 2/80



100-1010

100-1010

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  |   | REG. NO. 8 2 0 1 4 5 2   |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>CUNOVIA Melton RUSSELL</b>   |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR HOUR<br><b>1 4 82 130 PM</b>   |   |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Caucasian</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>04 30 13</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b> YRS.                                     |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MISSISSIPPI</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                     |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING YEARS)<br><b>Housewife</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b> |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD</b> 13b. CITY OR TOWN <b>ANNAPOLIS</b>   |  |   |  |   | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 13e. STREET ADDRESS<br><b>5 Cornwall St Annapolis</b>  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Unknown Melton Unknown</b>   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>No</b> (IF YES, GIVE WAR OR DATES) <b>—</b>  |  |   |  |   | 16b. SOCIAL SECURITY NO.<br><b>214-05-215</b>  |   | 17. INFORMANT<br>ADDRESS <b>Mrs. Jean King 331 Bell Street Neenah, Wisc.</b>   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Artery L</b><br><b>1629</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Hypoxia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Emphysematous Compression</b> |  |   |  |   |  |   |  |  | APPROXIMATE TIME BETWEEN ONSET AND DEATH<br><b>34456</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>Probable Smoke Inhalation</b>   |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>N/A</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>N/A</b>  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br><b>FALL</b>   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>Home</b>   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>3008 Baltimore</b>  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/4/82</b> , 19 <b>82</b> , to <b>1/4/82</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>1/4/82</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                    |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>James R. Belf</b>  |  |   |  |   | DEGREE<br><b>ATTENDING PHYSICIAN</b> <input type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input type="checkbox"/> |   |  | 22c. DATE SIGNED                                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>James R. Belf</b>   |  |   |  |   | 22e. ADDRESS<br><b>22 Greene St Baltimore</b>  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>   |  | 23b. DATE<br><b>Jan 6, 1982</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Brentwood PG MD</b>                  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>John M. Taylor &amp; Sons, Annapolis MD</b>  |  |   |  |   | 25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>JAN 6 1982</b>   |   |  |  |  |

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Handwritten notes at the top of the page, including the word "Horse" and other illegible scribbles.

Handwritten notes in the middle section, featuring the word "Horse" and other illegible scribbles.

Handwritten notes in the lower middle section, featuring the word "Horse" and other illegible scribbles.

Handwritten notes at the bottom of the page, including the word "Horse" and other illegible scribbles.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |  |   |  |                                |  |
|--|--|---|--|--|--|---|--|--------------------------------|--|
| 1. FOR STATE REGISTRAR   |  | 2a. DATE OF DEATH   |  | 3. REG. NO.  |  | 8 2 0 1 4 5 3   |  |                                |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST   |  | MIDDLE   |  | LAST  |  | 2b. HOUR                       |  |
| Thomas   |  |   |  |  |  | Ruth  |  | 24 PM                          |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | 7. IF UNDER 1 YEAR             |  |
| ♂  |  | B   |  | 3/22/13  |  | 68  |  | MONTHS DAYS HOURS MIN.         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                                |  |
| 3 Va.  |  | U.S.  |  |  |  | Baltimore City MD.  |  |                                |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                                |  |
| 38 Balt.   |  | Univ. of Md. Hosp.  |  |  |  |   |  |                                |  |
| 13a. STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS            |  |
| 35 Md.   |  |   |  | Balt.  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 2844 W. North Ave.             |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS          |  |
| 300 Henry  |  | Ruth  |  | Conella Moton  |  | 147038248   |  | Nora Cooper 2844 W. North Ave. |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Sepsis / dehydration<br>4439<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) Open infected wounds<br>(c) s/p Amputations for P.V.D.<br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a<br>ASCUD. |  |   |  |  |  |   |  |                                |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |                                |  |
|  |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |                                |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)  |  |   |  |                                |  |
|  |  | P.M. 19   |  |  |  |   |  |                                |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                     |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |                                |  |
|  |  |   |  |  |  |   |  |                                |  |
| 21g. I certify that (1) (this hospital) attended the deceased from 1/4 1981 to 1/4 1982, that (1) (we) last saw the deceased alive on 1/4 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.   |  |   |  |  |  |   |  |                                |  |
| 22a. SIGNATURE   |  | DEGREE  |  | 22b. DATE SIGNED   |  | 22c. DATE SIGNED  |  |                                |  |
| F.K. Dymd.   |  |   |  | 1/4/82   |  | 1/4/82  |  |                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |  |   |  |                                |  |
| Frederick Toy  |  | Univ. of Md. Hosp.  |  |  |  |   |  |                                |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |  |                                |  |
| Burial   |  | 1/11/82   |  | MD. VETERANS CEM.  |  | Crownsville MD  |  |                                |  |
| 24. FUNERAL DIRECTOR NAME  |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |                                |  |
| Wm. C. March F/H, Inc. 1101 E. North Ave.  |  | JAN 6 1982  |  | James J. Martin  |  |   |  |                                |  |



Rzeczkowski, Steve

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the hospital or attending physician.

DHMH-16 30M 2/80  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 8 2 0 1 4 5 4   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  |  |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Steve Rzeczkowski</b>   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>01/08/82</b>  |  | 2b. HOUR<br><b>2:58P<sub>M</sub></b>   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Caucasian</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>March 9, 1922</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>59</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Id</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>The Johns Hopkins Hospital</b> |  | 12a. USUAL OCCUPATION<br>(IF OF WORK, GIVE MOST OF WORKING LIFE)<br><b>Electrician</b>  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br><b>Baltimore</b>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE<br><b>Id.</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>619 S. Shryver St.</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Julian Rzeczowski</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>   |  |  |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES)<br><b>Yes WWII 1941-1945</b>  |  |  |  | 17. INFORMANT<br>NAME ADDRESS<br><b>Jessamine Rzeczowski 619 S. Shryver St.</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br><b>4275</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/8 1982</b> to <b>1/8 1982</b> , that (I) (we) last saw the deceased alive on <b>1/8 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                       |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Vladimir Svesuo MD</b>   |  |  |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>1/8/82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>VLADIMIR SVESUO MD</b>  |  |  |  | 22e. ADDRESS<br><b>JOHNS HOPKINS HOSPITAL</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>  |  | 23b. DATE<br><b>1-12-82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Stanislaus Cem.</b>  |  | 23d. LOCATION<br>CITY COUNTY STATE<br><b>Baltimore City Md.</b>  |  |
| 24. FUNERAL DIRECTOR<br><b>Raymond H. Rzeczowski</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 11 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>James J. [Signature]</b>  |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

782 01455

|   |  |   |  |
|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO.  |  |
| 1 DECEASED NAME (TYPE OR PRINT)<br>FAY M. SADLER  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>January 5, 1982   |  |
| 3 SEX<br>Female   |  | 2b. HOUR<br>1 PM  |  |
| 4. RACE<br>White  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>71 YRS.  |  |
| 5. DATE OF BIRTH MONTH DAY YEAR<br>April 15, 1910   |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>West Virginia  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Purchasing Agent - Union   |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1246 Sheridan Avenue  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Maryland 13b. COUNTY 13c. CITY OR TOWN Baltimore  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS Memorial Hospital 1246 Sheridan Avenue     |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>William Wesley Wolford   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Mary Elizabeth Carlisle   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No  |  | 16b. SOCIAL SECURITY NO. 212 32 1298  |  |
| 17. INFORMANT ADDRESS<br>Mr. Carl Sadler  |  | Same  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary occlusion</u><br>4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertension arteriosclerotic cardio</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) <u>vascular disease</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u><br><u>swyer.</u> |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>                                     |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  | 21g. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11-6</u> , 19 <u>59</u> , to <u>1-5</u> , 19 <u>82</u> , that (I) <u>was</u> last saw the deceased alive on <u>10-4</u> , 19 <u>81</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>was</u> (did not) view the body after death.  |  |   |  |
| 22b. SIGNATURE <u>Alfred G. Ossman Jr.</u> DEGREE   |  | 22c. DATE SIGNED <u>1/6/82</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Alfred G. Ossman, M.D.   |  | 22e. ADDRESS<br>1101 St. Paul St., Balto., Md.  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>1/8/82   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br>Mount Olivet  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Balto., Md.  |  |
| 24. FUNERAL DIRECTOR NAME<br>Henry W. Jenkins & Sons Co.<br>4905 York Road Balto., Md. 21212  |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br>JAN 8 1982 <u>James J. [Signature]</u>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in advance.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |                        |   |                          |  |                         |   |                                   |   |  |
|--|--|--|------------------------|---|--------------------------|--|-------------------------|---|-----------------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST<br><i>James</i>  | MIDDLE<br><i>James</i> | LAST<br><i>Sallee</i>   | 2a. DATE OF DEATH        |  | MONTH<br><i>1</i>       | DAY<br><i>9</i>   | YEAR<br><i>82</i>                 | 2b. HOUR<br><i>1A</i> M                         |  |
| 3. SEX<br><i>M</i>   |  | 4. RACE<br><i>Black</i>  |                        | 5. DATE OF BIRTH  |                          | 6. AGE (IN YEARS LAST BIRTHDAY)  |                         | IF UNDER 1 YEAR<br>MONTHS<br><i>68</i> YRS.   |                                   | IF UNDER 24 HRS.<br>HOURS<br>MIN.               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Atlantic City</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                          | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Balto. City</i> MD                        |                         |   |                                   |   |  |
| 10. CITY OR TOWN OF DEATH<br><i>Balto.</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Montebello Hosp.</i> |                        |   |                          | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     |                         |   | 12b. KIND OF BUSINESS OR INDUSTRY |   |  |
| 13a. STATE<br><i>Md.</i>   |  | 13b. COUNTY<br><i>Balto.</i>   |                        | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                          | 13d. STREET ADDRESS<br><i>111 W. Centre St.</i>                                      |                         |   |                                   |   |  |
| 14. FATHER'S NAME  |  | FIRST<br><i>James</i>  | MIDDLE                 | LAST<br><i>Sallee</i>   | 15. MOTHER'S MAIDEN NAME |  | FIRST<br><i>Estelle</i> | MIDDLE<br><i>Rinney</i>   | LAST                              |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |                        | 17. INFORMANT   |                          | ADDRESS  |                         |   |                                   |   |  |
| <i>No</i>  |  |  |                        | <i>Dorothy Farabee</i>  |                          | <i>201 N. Washington St.</i>   |                         |   |                                   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>LT CVA of RT hemisphere</i><br><i>1629</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>myocardial CA of hand palate</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>CA of prostate.</i>           |  |  |                        |   |                          |  |                         |   |                                   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><i>Infection of toe, peripheral vascular neuropathy</i>   |  |  |                        |   |                          |  |                         |   |                                   |   |  |
| 19a. DATE OF OPERATION<br><i>-</i>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>-</i>   |                        |   |                          | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                         | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <i>-</i> 19 <i>82</i>  |                        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><i>-</i>  |                          |  |                         |   |                                   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><i>-</i>   |                        | 21f. LOCATION<br>STREET<br><i>-</i>   |                          | CITY OR TOWN<br><i>-</i>   |                         | COUNTY<br><i>-</i>  |                                   | STATE<br><i>-</i>                               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1/9/82</i> to <i>Jan 9, 1982</i> , that (I) (we) lost<br>saw the deceased alive on <i>1/9/82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |                        |   |                          |  |                         |   |                                   |   |  |
| 22b. SIGNATURE<br><i>Michael Key</i>   |  |  |                        | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                   |                          |  |                         | 22c. DATE SIGNED  |                                   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>RASARAM</i>  |  |  |                        | 22e. ADDRESS<br><i>MONTBELLO HOSPITAL</i>   |                          |  |                         |   |                                   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>  |  | 23b. DATE<br><i>1/13/82</i>  |                        | 23c. NAME OF CEMETERY OR CREMATORY<br><i>King Mem. Pk.</i>  |                          | 23d. LOCATION<br>CITY OR TOWN<br><i>Balto. Md.</i>                                   |                         | COUNTY  |                                   | STATE   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Greg O'Brien</i>  |  |  |                        | 25a. DATE RECD. BY REGISTRAR<br><i>JAN 11 1982</i>  |                          |  |                         | 25b. REGISTRAR'S SIGNATURE<br><i>Thomas J. [Signature]</i>  |                                   |   |  |

Handwritten notes on lined paper, including the word "Library" and various illegible scribbles and markings.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO.  |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Mary Elizabeth Sampson</b>  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>01/12/82</b>   |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>12 28 1925</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS<br><b>56 55</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore</b> MD  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Johns Hopkins Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br><b>Maryland</b>   |  |  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Dundalk</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Isaac S. Bohrer</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Laura F.</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>215-22-6264</b>   |  | 17. INFORMANT ADDRESS<br><b>John L. Sampson 8220 Bear Creek Road Balto. MD 21222</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>HYPOTENSION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>MYOCARDIAL INFARCTION - CHRONIC SHOCK</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1/12</b><br><b>1/10</b><br><b>1/8 - 1/10/82</b> |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>possible septic shock</b>   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/10</b> , 19 <b>82</b> , to <b>1/12</b> , 19 <b>82</b> , that (I) (we) lost<br>saw the deceased alive on <b>1/12</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |
| 22b. SIGNATURE <b>Joseph A. Hearn</b> DEGREE  |  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>1/12/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JOSEPH A HEARN</b>  |  |  |  | 22e. ADDRESS<br><b>Johns Hopkins Hospital</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>1/15/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn Cemetery</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Duda-Ruck, Inc.</b> ADDRESS<br><b>7922 Wise Avenue, Dundalk, MD 21222</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR AND REGISTRAR'S SIGNATURE<br><b>JAN 14 1982 Thomas J. Nathan</b>  |  |  |  |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO. 8201458  |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>ALLEN</b> <b>SANSBURY</b>  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>JANUARY 5, 1982</b>   |  | 2b. HOUR <b>11:00</b> <sup>A</sup> <sub>M</sub>   |  |
| 3. SEX <b>Male</b>   |  | 4. RACE <b>Black</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>8 25 26</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>55</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>South Car.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto.,</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH <b>Balto.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Church Home Hosp.</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE <b>MD.</b>  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN <b>Balto.</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Walley</b> <b>Sansbury</b>  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>.Rosa</b>   |  | 13e. STREET ADDRESS <b>1923 Burnwood Rd.</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>  |  | 16b. SOCIAL SECURITY NO. <b>247 42 1621</b>   |  | 17. INFORMANT ADDRESS <b>Allen Sansbury, Jr. 1923 Burnwood Rd.</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b><br><b>1890</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CARCINOMA OF KIDNEY WITH BRAIN METASTASIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>DECEMBER 25, 81</b> , to <b>JANUARY 5, 1982</b> , that (I) (we) last saw the deceased alive on <b>JANUARY 5, 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did (did not) view the body after death.   |  |   |  |   |  |   |  |
| 22b. SIGNATURE <b>[Signature]</b>  |  |   |  | DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED <b>1/5/82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Y. K. SHETTY</b>  |  |   |  | ADDRESS <b>CHURCH HOSPITAL CORPORATION 100 N. BROADWAY, BALTIMORE, MD 21231</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  | 23b. DATE <b>1/9/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Westview Cem.</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO., MD.</b>  |  |
| 24. FUNERAL DIRECTOR NAME <b>Leroy E. Wyeth F.H.</b>   |  |   |  | 25a. DATE REG. BY REGISTRAR <b>JAN 7 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>   |  |





MAN & SON

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 1 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (1))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 2 0 1 4 5 9

FOR  
1- STATE  
REGISTRAR

|  |                  |  |   |   |  |   |  |   |  |
|--|------------------|--|---|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Bernard Sasscer   |                  |  |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED<br>1 18 1982   |  |   |  | 2b. HOUR<br>M<br>12:25<br>P M   |  |
| 3. SEX<br>Male   | 4. RACE<br>White | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 31 23   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>58 YRS. | 7. IF UNDER 1 YR.<br>MONTHS DAYS  |  | 7. IF UNDER 24 HRS.<br>HOURS MIN.   |  | 2c. DATE PRONOUNCED DEAD<br>1 18 1982   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                                     |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Mercy Hospital |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Manager                        |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>USA  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |                  |  |   |   |  |   |  |   |  |
| 13a. STATE<br>Maryland   |                  | 13b. CITY<br>Baltimore   |   | 13c. CITY OR TOWN<br>Rosedale   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>5 Clementine Ct  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William Sasscer  |                  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Anna Kimmarle  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>yes   |                  |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WW# 219-16-3714  |  | 17. INFORMANT<br>Margaret Sasscer<br>ADDRESS<br>5 Clementine Ct                                 |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u><br>4292<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |                  |  |   |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |                  |  |   |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |                  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                  |  |   |   |  |   |  |   |  |
| ACTUAL SIGNATURE<br><i>Thomas D. Smith</i>   |                  |  |   | TITLE (SPECIFY)<br>M.D. Deputy Chief  |  |   |  | DATE SIGNED<br>1/19/82  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Thomas D. Smith, M.D.  |                  |  |   | ADDRESS<br>111 Penn St. Balto., MD.   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |                  | 23b. DATE<br>1/22/82   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Dulaney Valley  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Cockeysville Balto MD                             |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Rosedale Funeral Home Inc  |                  |  |   | ADDRESS<br>12114 Sassa Ave  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 19 1982  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Thomas J. Smith</i>                                |  |

MEDICAL CERTIFICATION

HEAD ONLY



THE UNIVERSITY OF CHICAGO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |   |   |  |  |  | REG. NO. 82 01460  |  |
|---|--|---|--|---|---|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>FREDERICK A SAUER SR</b>   |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1/16/82</b> |   |  | 2b. HOUR<br>MIN.<br><b>3:25 PM</b>                                 |  |  |  |
| 3. SEX<br><b>M</b>  |  | 4. RACE<br><b>W</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7/25/02</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>1</b> MONTH <b>16</b> DAYS |  |  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>MD</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. CITY</b> MD.                                  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>LUTHERAN HOSP</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>LAND FILL</b>              |  |  |  |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>BALTO</b>   |  | 13c. CITY OR TOWN<br><b>MIDDLE RIVER</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1017 BOWLEYS QTRS</b>                    |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>LOUIS SAUER</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>KUMLEY HELLMAN</b>  |   |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>UNK</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>213 347 159</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>ELIZABETH SAUER ABOVE</b>  |   |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4960</b> IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Chronic Obstructive Lung Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Pneumonia</b> |  |   |  |   |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |  |   |   |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)                  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/31</b> , 19 <b>81</b> , to <b>1/16</b> , 19 <b>82</b> , that (I) (we) lost<br>saw the deceased alive on <b>1/16</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |   |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Mya Gebrewan</b>   |  |   |  |   |   | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>1/16/82</b>                                 |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Mya Gebrewan</b>  |  |   |  |   |   | 22e. ADDRESS  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>BURIAL</b>  |  |   | 23b. DATE<br><b>1/20/82</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>OAK LAWN</b> |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO. MD.</b>    |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>J.G. CONNELLY SONS</b>   |  |   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 19 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Frances Jan Nathan</b>            |  |  |  |

1941-1942

1941-1942

1941-1942

1941-1942

1941-1942

1941-1942

1941-1942

TO HOSPITALS, ATTENDING PHYSICIANS: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8 2 0 1 4 6 1   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>Lillian Savage   |  |   |  | 2a. DATE OF DEATH<br>1 16 1982  |  | 2b. HOUR<br>M  |  |
| 3. SEX<br>female   |  | 4. RACE<br>black  |  | 5. DATE OF BIRTH<br>2 12 1897   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>84 YRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore city MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>825 N. Broadway Apt 107 |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>Md   |  | 13b. COUNTY<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13c. STREET ADDRESS<br>1535 N. Wolfe Street  |  |
| 14. FATHER'S NAME<br>James E. Wise   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>Ollie Dennis  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>212-30-1293   |  | 17. INFORMANT ADDRESS<br>Lillian D. Sheppard 1535 N. Wolfe Street   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u><br>1629 } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>LIGHT UPPER LOBE LARGE CELL CARCINOMA</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>1 MD</u> |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>PNEUMONIA</u>  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>DECEMBER 19, 81</u> , to <u>JANUARY 12, 1982</u> , that (I) (we) lost saw the deceased alive on <u>JANUARY 12, 1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>W. F. Ginez</u>   |  |   |  | DEGREE<br>M.D.  |  | 22c. DATE SIGNED<br>1/18/82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>LUIS F. GIMENEZ   |  |   |  | 22e. ADDRESS<br>JOHNS HOPKINS HOSPITAL BALD. MD 21205   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>1/21/82  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore Cemetery  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>William C. March F/H 1101 E. North Avenue  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 19 1982  |  |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   | 8 2 0 1 4 6 2  |  |   |  |                             |   |  |       |  |
|--|--|--|--|---|--|--|---|--|-----------------------------|---|--|-------|--|
| 1. FOR STATE REGISTRAR   |  |  |  |   | REG. NO.   |  |   |  |                             |   |  |       |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>WILLIAM Thomas SCHAFER</b>  |  |  |  |   | 2a. DATE OF DEATH<br>MONTH <b>1</b> DAY <b>24</b> YEAR <b>82</b>   |  |   |  | 2b. HOUR<br><b>10 20</b> AM |   |  |       |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>CAUCASIAN</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>9</b> DAY <b>19</b> YEAR <b>17</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b> YRS.                                      |   | 7. IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>  |                             | 7b. IF UNDER 24 HRS<br>HOURS <b></b> MIN <b></b>    |  |       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore</b> MD.                           |   |  |                             |   |  |       |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore City Hospitals</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Beth. Steel</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY  |                             |   |  |       |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Md.</b> 13b. COUNTY <b>Balto.</b> 13c. CITY OR TOWN <b>Balto.</b>  |  |  |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>628 S. Ellwood Ave.</b>     |  |                             |   |  |       |  |
| 14. FATHER'S NAME<br>FIRST <b>Philip</b> MIDDLE <b>Schafer</b> LAST <b>Schafer</b>   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Stella</b> MIDDLE <b>McKenzie</b> LAST <b>McKenzie</b>  |  |   |  |                             |   |  |       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>no</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>214-05-9450</b>   |  | 17. INFORMANT<br><b>M's. Elizabeth Kulski, same</b>   |  | ADDRESS  |   |  |                             |   |  |       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b>   |  |  |  |   |  |  |   |  |                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH        |  |       |  |
| 2391<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |  |   |  |  |   |  |                             | DUE TO, OR AS A CONSEQUENCE OF (b) <b>PNEUMONIA</b> |  | 1 DAY |  |
|  |  |  |  |   |  |  |   |  |                             | DUE TO, OR AS A CONSEQUENCE OF (c) <b>LUNG MASS</b> |  |       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>PROBABLE LIVER METASTASES</b>  |  |  |  |   |  |  |   |  |                             |   |  |       |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>              |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                             |   |  |       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |   |  |                             |   |  |       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |  |                             |   |  |       |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/18</b> 19 <b>82</b> , to <b>1/24</b> 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>1/24</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |   |  |                             |   |  |       |  |
| 22b. SIGNATURE<br><b>Conrad May</b>  |  |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   |  |                             | 22c. DATE SIGNED<br><b>1/24/82</b>                  |  |       |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CONRAD MAY</b>   |  |  |  |   | 22e. ADDRESS<br><b>BALTIMORE CITY HOSPITALS</b>  |  |   |  |                             |   |  |       |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>1/27/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holly Hills Mem.</b>   |  | 23d. LOCATION<br>CITY OR TOWN <b>Baltimore, Md.</b> COUNTY <b></b> STATE <b></b>       |   |  |                             |   |  |       |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Zannino Funeral Home, 263 S. Conkling</b> ADDRESS <b>St.</b>   |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 26 1982</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>James Van Wather</b> |  |                             |   |  |       |  |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon-copiers, Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 4 6 3

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  | 2a. DATE OF DEATH  |  | MONTH DAY YEAR  |  | 2b. HOUR  |  |
| 1 DECEASED NAME (TYPE OR PRINT)   |  | FIRST MIDDLE LAST  |  | 1 19 82   |  | 5 P.M.  |  |
| 3 SEX   |  | 4 RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  |
| FEMALE  |  | WHITE  |  | MONTH DAY YEAR<br>JULY 4, 1891  |  | 90 YRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                                 |  |
| MARYLAND  |  | USA  |  |   |  | BALTIMORE CITY MD   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |
| BALTIMORE   |  | 6317 PARK HTS. AVE., APT. T-2  |  | HOUSEWIFE   |  | AT HOME   |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  |
| MARYLAND  |  |  |  | BALTIMORE   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14 FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  | 13e. STREET ADDRESS   |  | APT. T-2  |  |
| FIRST MIDDLE LAST<br>MAX LANSBURG   |  | FIRST MIDDLE LAST<br>JENNIE UNKNOWN  |  | 6317 PARK HTS. AVE. #21215  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17 INFORMANT  |  | ADDRESS   |  |
| NO  |  | 219-32-5758  |  | MR. ABRAHAM SCHECHTER   |  | SCHECHTER   |  |
|   |  |  |  | 6317 PARK HTS. AVE., APT. T-2   |  | #21215  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Hypertensive Cardio Vascular Disease</u><br>4029<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF |  |  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>20 years |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>Aortic Stenosis (2) M. TRAL INSUFFICIENCY</u>   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |
| NONE  |  | NONE   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                 |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
|   |  |  |  |   |  |   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>JANUARY 1, 19 82</u> to <u>JANUARY 19, 19 82</u> , that (I) (we) saw the deceased alive on <u>JANUARY 8, 19 82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                  |  |  |  |   |  |   |  |
| 22b. SIGNATURE  |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED  |  |
| Melvin N. Borden M.D.   |  | M.D.   |  |   |  | 1/19/82   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  | 22f. ADDRESS  |  |   |  |
| Melvin N. BORDEN M.D.   |  | 5000 BALTO NAT'L PIKE<br>BALTO MD 21229  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION   |  |
| BURIAL  |  | JAN. 21, 1982  |  | BNAI ISRAEL   |  | BALTIMORE MARYLAND  |  |
| 24 FUNERAL DIRECTOR SOL LEVINSON & BROS., INC.<br>NAME ADDRESS<br>6010 REISTERSTOWN RD. BALTO., MD 21215  |  |  |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |
|   |  |  |  | JAN 27 1982   |  | James Van Natten  |  |

MEDICAL CERTIFICATION

2740 BP



JAN 21 1953

RECEIVED

WILLIS



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 8 2 0 1 4 6 4   |  |  |   |
|--|--|---|--|---|--|--|---|
| FOR STATE REGISTRAR  |  |   |  | REG. NO.  |  |  |   |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Anna L. Schedel</b>  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>January 22, 1982</b>   |  | 2b. HOUR<br><b>6 A</b> M   |   |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>December 8, 1906</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>342 W. 29th Street</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>   |  |   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Samuel Ray</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Amanda Simmond</b>   |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>217 07 4886A</b>   |  | 17. INFORMANT<br><b>George R. Schedel</b>   |  | ADDRESS<br><b>Same</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pneumonia, terminal</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute congestive failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerotic heart disease</b><br>4140<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 day</b><br><b>3 hrs</b><br><b>7 yr</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:<br><b>Diabetes mellitus; surgical absence of A. low extremity</b>   |  |   |  |   |  |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)  |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/3</b> 19 <b>70</b> to <b>1/22</b> 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>1/21</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |   |
| 22b. SIGNATURE<br><b>[Signature]</b>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>1/22/82</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Marlon Friedman</b>  |  |   |  | 22e. ADDRESS<br><b>5211 Harford Road Baltimore, Md.</b>   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>25 Jan. 1982</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Park Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Woodlawn, Balto. Co. Md.</b>  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Burgee Funeral Home 3631 Falls Road 21211</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 26 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH - 16 50M 1/81  
(VRA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 8 2 0 1 4 6 5  |  |  |  |
|--|--|--|--|--|--|--|--|
| FOR STATE REGISTRAR  |  |  |  | CERTIFICATE OF DEATH   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  |  | 2a. DATE OF DEATH  |  |  |  |
| FIRST MIDDLE LAST  |  |  |  | MONTH DAY YEAR   |  |  |  |
| GLENROY C. SCHISSLER, Sr.  |  |  |  | 1-26-82  |  |  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                |  |
| M  |  | W  |  | MONTH DAY YEAR   |  | 79 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |  |
| MARYLAND   |  | U.S.A.   |  |  |  | BALTIMORE CITY - MD.   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| BALTO.   |  | CHURCH HOSPITAL  |  | STORE ROOM ATT. CROWN CORP SEAL  |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  | 13d. INSIDE CITY LIMITS?   |  |  |  |
| 13a. STATE 13b. COUNTY 13c. CITY OR TOWN   |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| MD. — BALTO.   |  |  |  | 13e. STREET ADDRESS  |  |  |  |
|  |  |  |  | 427 N. MILTON AVE.   |  |  |  |
| 14. FATHER'S NAME (FIRST MIDDLE LAST)  |  |  |  | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)   |  |  |  |
| WILLIAM C. SCHISSLER   |  |  |  | ANNA COLE  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |  |  |  |
| No   |  | 212-09-7208  |  | Mrs. Teresa B. Schissler - 427 N. Milton Ave.  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST   |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |
| (b) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE   |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |
| (c) MYOCARDIAL INFARCTION  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |
|  |  | P.M. 19  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |
|  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/22, 19 82, to 1/26, 19 82, that (I) (we) last saw the deceased alive on 1/26, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE   |  |  |  | DEGREE   |  | 22c. DATE SIGNED   |  |
| Walter Bender  |  |  |  | MD   |  | 1/26/82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | 22e. ADDRESS   |  |  |  |
| WALTER BENDER, MD.   |  |  |  | CHURCH HOSPITAL CORPORATION 100 N. BROADWAY BALTIMORE, MARYLAND 21231  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                        |  |
| BURIAL   |  | 1-29-82  |  | HOLY REDEEMER  |  | BALTO., MD.  |  |
| 24. FUNERAL DIRECTOR NAME  |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE                                     |  |
| Hartley Miller - 7527 Harford Rd.  |  |  |  | JAN 28 1982  |  | Theresa Jean Thorton   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

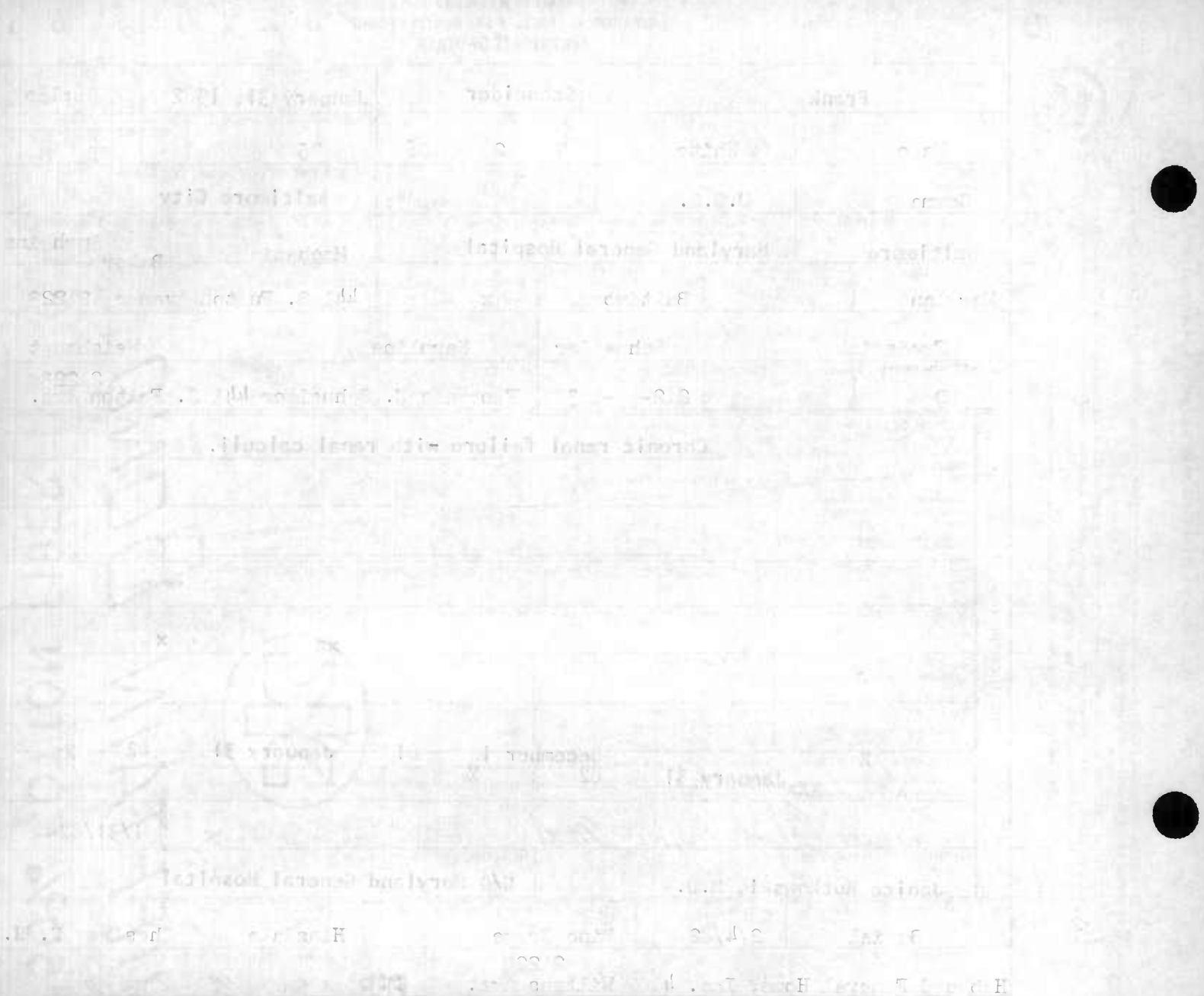
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16.50M 1/81  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |   |  | REG. NO. 8 2 0 1 4 6 6   |  |  |  |                            |  |
|---|--|---|--|---|--|---|--|---|--|--|--|--|--|----------------------------|--|
| 1. FOR STATE REGISTRAR  |  | I. DECEASED NAME<br>(TYPE OR PRINT) <b>Frank Schneider</b>  |  |   |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 31, 1982</b> |  |  |  | 2b. HOUR<br><b>8:15p M</b> |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 26 06</b>  |  | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>75</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>75</b>   |  | IF UNDER 74 HRS.<br>HOURS MIN.<br><b>75</b>                    |  |  |  |                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Germany</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD.</b>                               |  |   |  |  |  |  |  |                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Mechanic</b>             |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Bakery</b>  |  |  |  |  |  |                            |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>441 S. Fulton Avenue 21223</b>  |  |  |  |  |  |                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Frederick Schneider</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Karoline Weishaupt</b>  |  |   |  |   |  |  |  |  |  |                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>212-09-1830</b>  |  | 17. INFORMANT<br><b>Florence E. Schneider</b>   |  |   |  | ADDRESS<br><b>441 S. Fulton Ave. 21223</b>  |  |  |  |  |  |                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Chronic renal failure with renal calculi.</b><br>5850<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) }<br>(c) }<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF |  |   |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |  |   |  |   |  |   |  |  |  |  |  |                            |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |                            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |   |  |  |  |  |  |                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |  |  |  |  |                            |  |
| 22a. I certify that (this hospital) attended the deceased from <b>December 1</b> , 19 <b>81</b> , to <b>January 31</b> , 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>January 31</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                    |  |   |  |   |  |   |  |   |  |  |  |  |  |                            |  |
| 22b. SIGNATURE<br><i>Janice Rutkowski, M.D.</i><br>DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>   |  |   |  |   |  | 22c. DATE SIGNED<br><b>1/31/82</b>  |  |   |  |  |  |  |  |                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Janice Rutkowski, M.D.</b>  |  |   |  |   |  | 22e. ADDRESS<br><b>C/O Maryland General Hospital</b>  |  |   |  |  |  |  |  |                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>2/4/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Pine Grove</b>   |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Hinsdale Chesire N. H.</b>   |  |  |  |  |  |                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Hubbard Funeral Home, Inc.</b>   |  |   |  |   |  | ADDRESS<br><b>4107 Wilkens Ave.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 3 1982</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Janice Rutkowski</i>          |  |  |  |                            |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

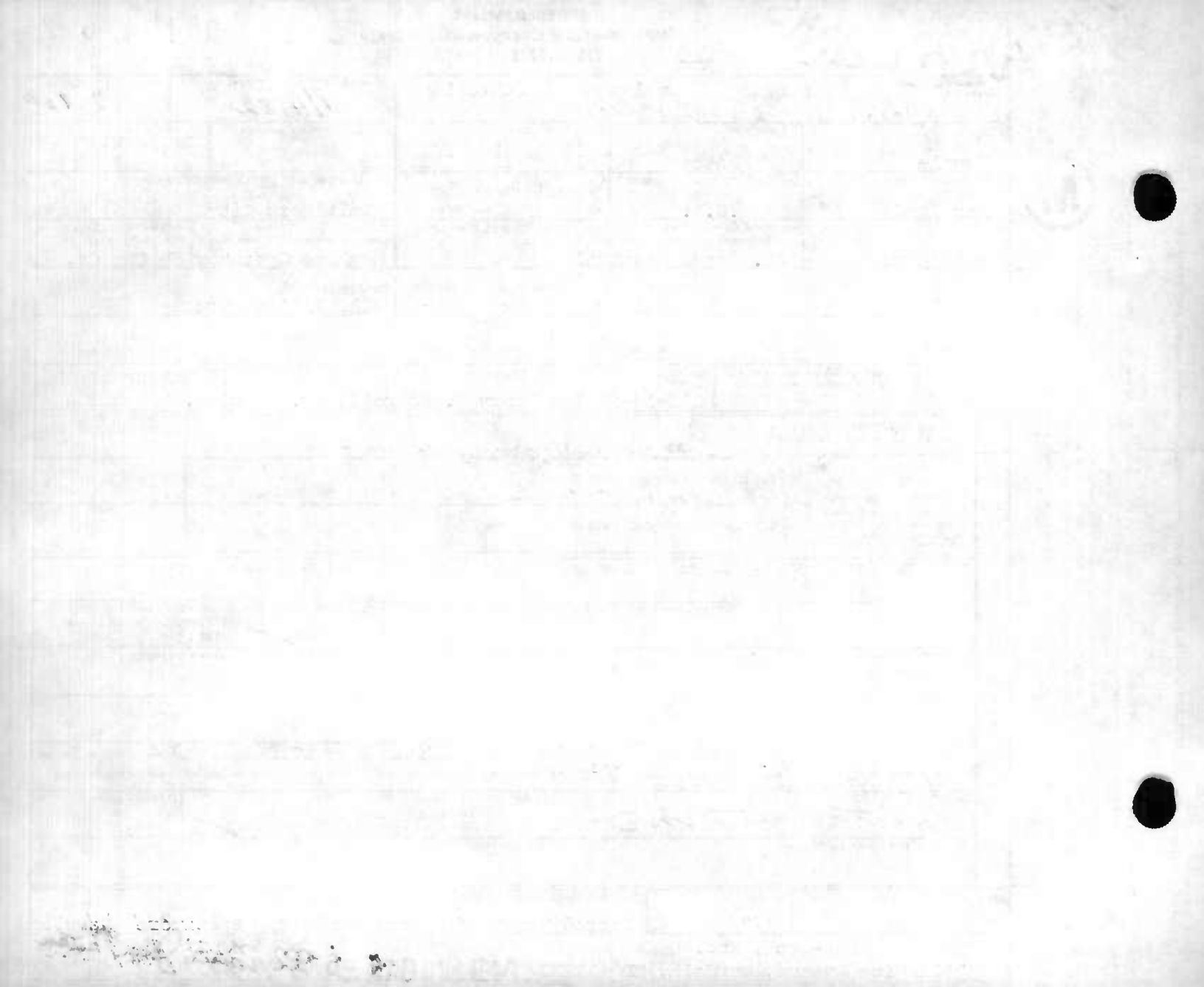
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  | 8 2 0 1 4 6 7            |   |
|---|--|---|--|--|--------------------------|---|
| 1. FOR STATE REGISTRAR <i>Dolores E</i>   |  |   | REG. NO.   |  |                          |   |
| 1. DECEASED NAME (TYPE OR PRINT) <i>Dolores Evelyn Schroll</i>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR <i>1/4/82</i>   |  | 2b. HOUR <i>2:00 A M</i> |   |
| 3 SEX <i>Female</i>   | 4 RACE <i>White</i>  | 5 DATE OF BIRTH MONTH DAY YEAR <i>12 21 1922</i>  | 6 AGE (IN YEARS LAST BIRTHDAY) <i>59</i> YRS.  | IF UNDER 1 YEAR MONTHS DAYS  |                          | IF UNDER 24 HRS. HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>   | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.                                |  |                          |   |
| 10 CITY OR TOWN OF DEATH <i>Baltimore</i>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>St. Agnes Hospital</i> |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Machine Operator</i>        | 12b. KIND OF BUSINESS OR INDUSTRY <i>MD Cup Co.</i>  |                          |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |  |                          |   |
| 13a. STATE <i>Maryland</i>  | 13b. COUNTY  | 13c. CITY OR TOWN <i>Baltimore</i>  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS <i>3213 Dillon Street</i>  |                          |   |
| 14 FATHER'S NAME FIRST MIDDLE LAST <i>John Carl Burns</i>   |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Elizabeth Falkenham</i>  |  |  |                          |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>   |  | 16b. SOCIAL SECURITY NO. <i>215-14-9107</i>   |  | 17. INFORMANT ADDRESS <i>7857 Kavanagh Road</i>  |                          |   |
|   |  | <i>Henry G. Schroll, Sr.</i>  |  | <i>Balto. MD 21222</i>   |                          |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <i>Cardio-Pulmonary Arrest</i><br><i>4275</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Major Organ Failure</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |  |                          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |  |  |                          |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                          | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                          |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |                          |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>10/10</i> , 19 <i>81</i> , to <i>1/4</i> , 19 <i>82</i> , that (I) (we) lost saw the deceased alive on <i>1/4</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                           |  |   |  |  |                          |   |
| 22b. SIGNATURE <i>[Signature]</i>   |  | DEGREE  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                          | 22c. DATE SIGNED  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS  |  |  |                          |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>   |  | 23b. DATE <i>1/7/82</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY <i>Sacred Heart of Jesus</i>  |                          | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Dundalk Baltimore Maryland</i>   |
| 24 FUNERAL DIRECTOR NAME <i>Duda-Ruck, Inc.</i>   |  | ADDRESS <i>7922 Wise Avenue, Dundalk, MD 21222</i>  |  | 25a. DATE REC'D. BY REGISTRAR <i>JAN 6 1982</i>  |                          | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copies. Pages 1 and 2 should be filed within 2 weeks after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |   |                                    |  |  |                           |  |  |          |  |
|---|--|--|---|---|------------------------------------|--|--|---------------------------|--|--|----------|--|
| 1. FOR STATE REGISTRAR  |  | 8 2 0 1 4 6 8  |   | REG. NO.  |                                    |  |  |                           |  |  |          |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  | FIRST MIDDLE LAST   |   |                                    | 2a. DATE OF DEATH  |  |                           | MONTH DAY YEAR   |  | 2b. HOUR |  |
| Adam Joseph Schultz Jr.   |  |  |   |   |                                    | 1 13 82  |  |                           | 10: P  |  | M        |  |
| 3 SEX   |  | 4. RACE  |   | 5. DATE OF BIRTH  |                                    | 6 AGE (IN YEARS LAST BIRTHDAY)   |  | IF UNDER 1 YEAR           |  | IF UNDER 24 HRS                              |          |  |
| MALE  |  | WHITE  |   | MONTH DAY YEAR  |                                    | 76 YRS.  |  | MONTHS DAYS               |  | HOURS MIN.                                   |          |  |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |   | 8. MARRIAGE STATUS  |                                    | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |                           |  |  |          |  |
| Baltimore, Md.  |  | USA  |   | MARRIED <input checked="" type="checkbox"/> <del>UNMARRIED</del> <del>WIDOWED</del> <del>DIVORCED</del> <input checked="" type="checkbox"/> |                                    | Baltimore City MD.   |  |                           |  |  |          |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |   |                                    | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |                           | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |          |  |
| Baltimore   |  | St. Agnes Hospital   |   |   |                                    | Retired  |  |                           | Amer. Smelting   |  |          |  |
| 13a. STATE  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN   |                                    | 13d. INSIDE CITY LIMITS?   |  | 13e. STREET ADDRESS       |  |  |          |  |
| MD.   |  | Balto.   |   | Edmonson Hgts.  |                                    | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 1506 Langford Road        |  |  |          |  |
| 14. FATHER'S NAME   |  |  |   | 15. MOTHER'S MAIDEN NAME  |                                    |  |  |                           |  |  |          |  |
| FIRST MIDDLE LAST   |  |  |   | FIRST MIDDLE LAST   |                                    |  |  |                           |  |  |          |  |
| Adam Joseph Schultz Sr.   |  |  |   | Anna Kuyawa   |                                    |  |  |                           |  |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT   |                                    | ADDRESS  |  |                           |  |  |          |  |
| No  |  | 212-10-1643  |   | Anna J. Murray Daughter   |                                    | 1506 Langford Rd.  |  |                           |  |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:   |  |  |   |   |                                    |  |  |                           |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |          |  |
| IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u>   |  |  |   |   |                                    |  |  |                           |  |  |          |  |
| 4100  |  |  |   |   |                                    |  |  |                           |  |  |          |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |   |   |                                    |  |  |                           |  |  |          |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last   |  |  |   |   |                                    |  |  |                           |  |  |          |  |
| (b) <u>Acute Myocardial Infarction</u>  |  |  |   |   |                                    |  |  |                           |  |  |          |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |   |   |                                    |  |  |                           |  |  |          |  |
| (c)   |  |  |   |   |                                    |  |  |                           |  |  |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |   |                                    |  |  |                           |  |  |          |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |                                    |  | 20a. AUTOPSY?  |                           | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |          |  |
|   |  |  |   |   |                                    |  | YES <input type="checkbox"/> NO <input type="checkbox"/> |                           | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY   |   |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |                           |  |  |          |  |
|   |  |  | HOUR A.M. MONTH DAY YEAR  |   |                                    |  |  |                           |  |  |          |  |
|   |  |  | P.M. 19   |   |                                    |  |  |                           |  |  |          |  |
| 21d. INJURY OCCURRED  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |                                    | 21f. LOCATION  |  |                           |  |  |          |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK   |  |  |   |   |                                    | CITY OR TOWN COUNTY STATE  |  |                           |  |  |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 13</u> , 19 <u>82</u> , to <u>Jan 13</u> , 19 <u>82</u> , that (I) (we) lost  |  |  |   |   |                                    |  |  |                           |  |  |          |  |
| saw the deceased alive on <u>Jan 13</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |   |                                    |  |  |                           |  |  |          |  |
| 22b. SIGNATURE  |  |  | DEGREE  |   |                                    | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |                           | 22c. DATE SIGNED   |  |          |  |
| <u>Oscar G. Hernandez</u>   |  |  | M.D.  |   |                                    |  |  |                           | 1-13-82  |  |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  | 22e. ADDRESS  |   |                                    |  |  |                           |  |  |          |  |
| Oscar G. Hernandez, M.D.  |  |  | St. Agnes Hospital<br>900 Caton Ave.-Balto., Md. #21229             |   |                                    |  |  |                           |  |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORY |  |  | 23d. LOCATION             |  |  |          |  |
| Burial  |  |  | 1-18-82   |   | St. Stanislaus Cem.                |  |  | CITY OR TOWN COUNTY STATE |  |  |          |  |
|   |  |  |   |   |                                    |  |  | Baltimore City, Md.       |  |  |          |  |
| 24. FUNERAL DIRECTOR  |  |  | 25a. DATE OF REGISTRATION   |   |                                    |  |  |                           |  |  |          |  |
| C.S. Zeiler & Son Inc. 901 S. Conkling Street   |  |  | JAN 18 1982   |   |                                    |  |  |                           |  |  |          |  |







ENVELOPE

0 032 TS 93 0 0

50% COTTON 45% P

100% Cotton 45% P

Item 5 g564 2/17/82 gj

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

B 2 0 1 4 7 0

REG. NO.

|   |   |   |   |  |  |
|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Richard F. SCOTT, Sr.  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>January 18, 1982   |  | 2b. HOUR<br>6:40P M  |
| 3. SEX<br>Male  | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>May 18, 1982 1910   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>71 YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>6117 Marietta Avenue |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Clerk-Mail  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Banking   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |   |   |   |  |  |
| 13a. STATE<br>Maryland  | 13b. COUNTY<br>-----  | 13c. CITY OR TOWN<br>Baltimore  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   | 13e. STREET ADDRESS<br>6117 Marietta Avenue  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Harry E. Scott  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Carrie Mary Thomas   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>-----  | 17. INFORMANT ADDRESS<br>Irene E. Scott 6117 Marietta Avenue Balto.,  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u><br>4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>1 mo &amp; 4 days</u> |   |   |   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |   |   |   |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>2/24/81</u> 19____, to <u>1/18/82</u> 19____, that (1) (we) lost saw the deceased alive on <u>2/24/81</u> 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.  |   |   |   |  |  |
| 22b. SIGNATURE<br><u>E. J. Zick</u>   |   |   | DEGREE<br><u>M.D.</u><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>Jan 20, 82   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Thomas C. Folkemer, M.D.   |   |   | 22e. ADDRESS<br>3708 Mountain Road Pasadena, Maryland   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  | 23b. DATE<br>Jan 22, 82   | 23c. NAME OF CEMETERY OR CREMATORY<br>Gardens of Faith Cem  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Co., Md.  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Dippel Funeral Homes, Inc.  |   |   | ADDRESS<br>7110 Belair Road<br>Baltimore, Md.   |  | 25a. DATE REC'D. BY REGISTRAR (1) REGISTRAR'S SIGNATURE<br>JAN 21 1982 <u>Frances Jan Nathan</u>                           |

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY



UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.



JAN 31 1935  
J. H. K. H. K.

United States Department of Agriculture  
Bureau of Plant Industry

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 4 7 1

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |                           |  |
|---|--|---|--|---|---------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>LOUIS F. SEIDEL Sr.</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 2 82</b> |   | 2b. HOUR<br><b>9:05 P</b> |  |
| 3 SEX<br><b>Male</b>  |  | 4 RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 10 04</b>                                      |                           |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77 YRS</b>  |  | 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>MD.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |                           |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>CITY</b>  |  |   |                           |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>S B G H</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED Tailor</b> |                           |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>CLOTHING</b>  |  | 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>A.A. Co.</b>  |                           |  |
| 13c. CITY OR TOWN<br><b>BALTO</b>   |  | 13d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                             |  | 13e. STREET ADDRESS<br><b>9 14<sup>TH</sup> ST., 21225</b>                                |                           |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>WILLIAM J SEIDEL</b>  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARY SCHWEISER</b>   |  |   |                           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>216 24 2353</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>C. ZIGEL MD 3001 S. HANOVER</b>                            |                           |  |

## MEDICAL CERTIFICATION

|   |  |   |
|---|--|---|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Liver Cancer</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
|---|--|---|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/23 19 81</b> to <b>1/2 19 82</b> , that (I) (we) lost<br>saw the deceased alive on <b>1/2 19 82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Carlos Zigel</b>  |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1/2/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CARLOS ZIGEL</b>   |  |  |  | 22e. ADDRESS<br><b>3001 S. HANOVER ST.</b>   |  |   |  |

|   |  |                              |  |   |  |  |  |
|---|--|------------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>  |  | 23b. DATE<br><b>1/6/1982</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b> |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>McQuilly Funeral Home</b> |  |                              |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 7 1982</b>                |  | 25b. REGISTRAR'S SIGNATURE<br><b>James J. Nathan</b>                     |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-1650M/181  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |   |  | REG. NO.   |  |
|--|--|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JOSEPH C. SEIFERT</b>   |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH <b>1</b> DAY <b>15</b> YEAR <b>82</b>                      |  | 2b. HOUR<br><b>10:43 AM</b>   |  |  |  |
| 3. SEX<br><b>M</b>   |  | 4. RACE<br><b>W</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>3</b> DAY <b>3</b> YEAR <b>04</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS.                                     |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>  |  | IF UNDER 24 HRS.<br>HOURS <b></b> MIN. <b></b>     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>BALTO. MD</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD</b>                      |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MERCY HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Supervisor</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Food Mfg Corp</b>   |  |  |  |
| 13a. STATE<br><b>MD.</b>   |  |  |  | 13b. COUNTY<br><b>BALTO.</b>  |  | 13c. CITY OR TOWN<br><b>BALTO.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                               |  | 13e. STREET ADDRESS<br><b>140 HOLLOW BROOK RD.</b> |  |
| 14. FATHER'S NAME<br><b>Charles</b> MIDDLE <b>Seifert</b> LAST   |  |  |  | 15. MOTHER'S MAIDEN NAME<br><b>Josephine</b> MIDDLE <b>Ziomiek</b> LAST   |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>   |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>213-01-9370</b>  |  | 17. INFORMANT<br><b>Family RECORDS</b>  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOGENIC SHOCK, PULMONARY EDEMA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>MYOCARDIAL INFARCTION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ASCVD</b>  |  |  |  |   |  |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>CANCER OF BLADDER CHRONIC RENAL FAILURE</b>   |  |  |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>—</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>—</b>   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>—</b>  |  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/15</b> , 19 <b>82</b> , to <b>1/15</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>1/15</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Stephen D. Campbell</b>   |  |  |  | DEGREE  |  |   |  | 22c. DATE SIGNED  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>STEPHEN D. CAMPBELL</b>  |  |  |  | 22e. ADDRESS<br><b>MERCY HOSPITAL</b>   |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>BURIAL</b>   |  | 23b. DATE<br><b>1-18-82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HOLY CROSS LEM</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ANNIE ARNOLD MD</b>                  |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Evans Chapel of Chimney</b> ADDRESS <b>2325 York Rd</b>  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 19 1982</b>                                   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles J. Nathan</b>  |  |  |  |

MEDICAL CERTIFICATION





Handwritten text, possibly a signature or name, located in the upper middle section of the page.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |   | 8 2 0 1 4 7 3  |  |
|---|--|---|---|--|--|
| 1. FOR STATE REGISTRAR  |  |   |   | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>LLOYD Franklin SEIPLER   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1-19-82                              |  | 2b. HOUR<br>3:15AM   |
| 3. SEX<br>Male  | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4 13 14   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>67 YRS                                      | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                     |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Church Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired | 12b. KIND OF BUSINESS OR INDUSTRY<br>Balto. City                               |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland  |  |   | 13b. COUNTY<br>-----  | 13c. CITY OR TOWN<br>Baltimore   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Assard ----- Seipler  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Catherine ----- Feller     |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE YEAR OR DATES)<br>N.W. 11   | 17. INFORMANT ADDRESS<br>Doris W. Seipler 424 N. Belnord Avenue 21224       |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST<br>4280<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) RENAL FAILURE<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) CONGESTIVE HEART FAILURE |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>5 MINUTES<br>3 DAYS<br>1 MONTH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (If this hospital attended the deceased from 1-5 19 82, to 1-19 19 82, that (I/we) last saw the deceased alive on 1-19 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did not) view the body after death.   |  |   |   |  |  |
| 22b. SIGNATURE<br>S. O. GOTTHEB, MD,  |  | DEGREE<br>M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |   | 22c. DATE SIGNED<br>1/19/82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS<br>CHURCH HOSPITAL CORPORATION 100 N. BROADWAY BALTIMORE, MARYLAND 21231   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   | 23b. DATE<br>1-22-82   | 23c. NAME OF CEMETERY OR CREMATORY<br>Eastview Mem. Park  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. City Md.                  |  |
| 24. FUNERAL DIRECTOR<br>C.S. Zeiler & Son Inc. 901 S. Conkling Street   |  | 25a. DATE RECD. BY REGISTRAR<br>JAN 21 1982   |   |  |  |

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Figure 1

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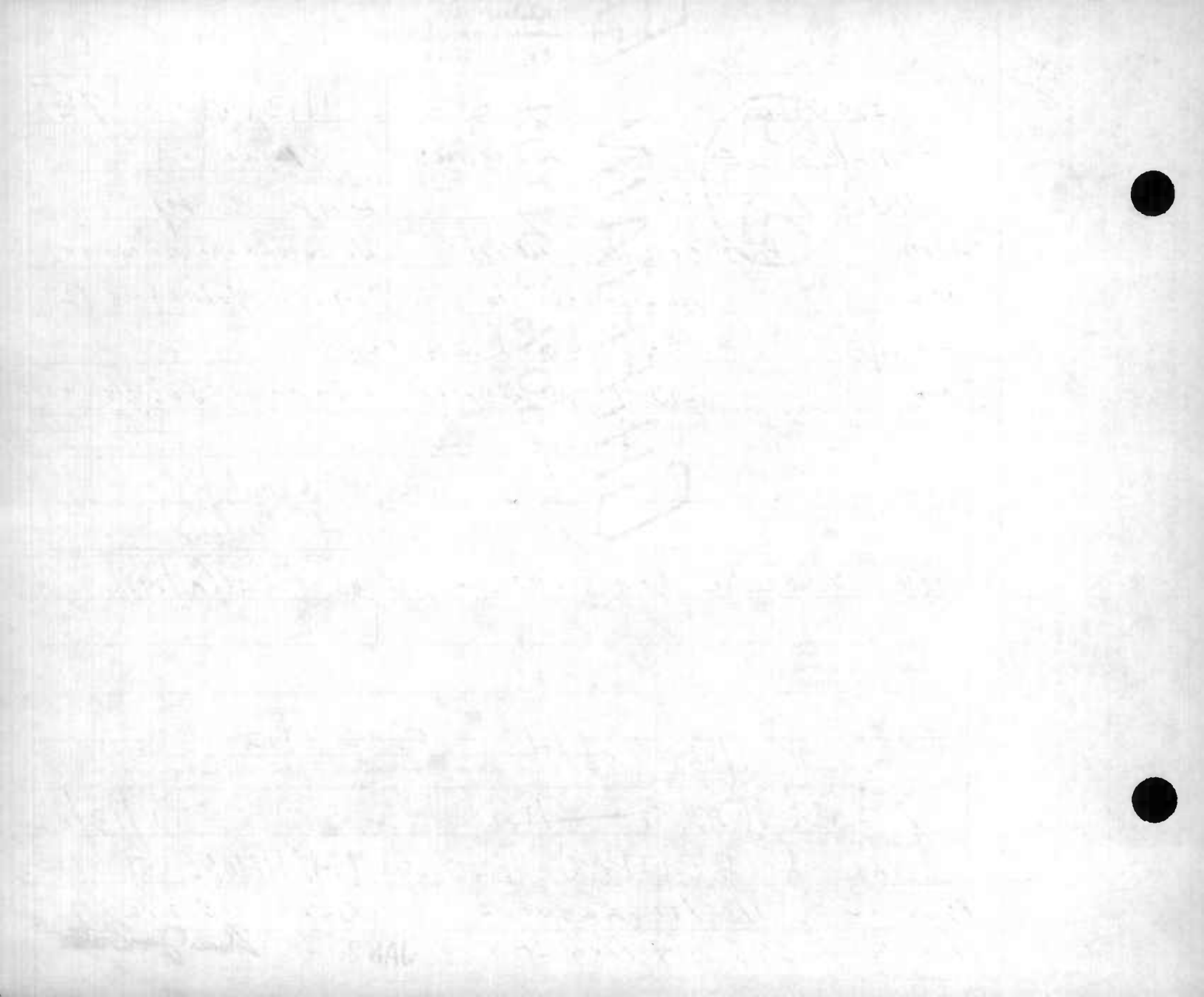
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## MEDICAL CERTIFICATION

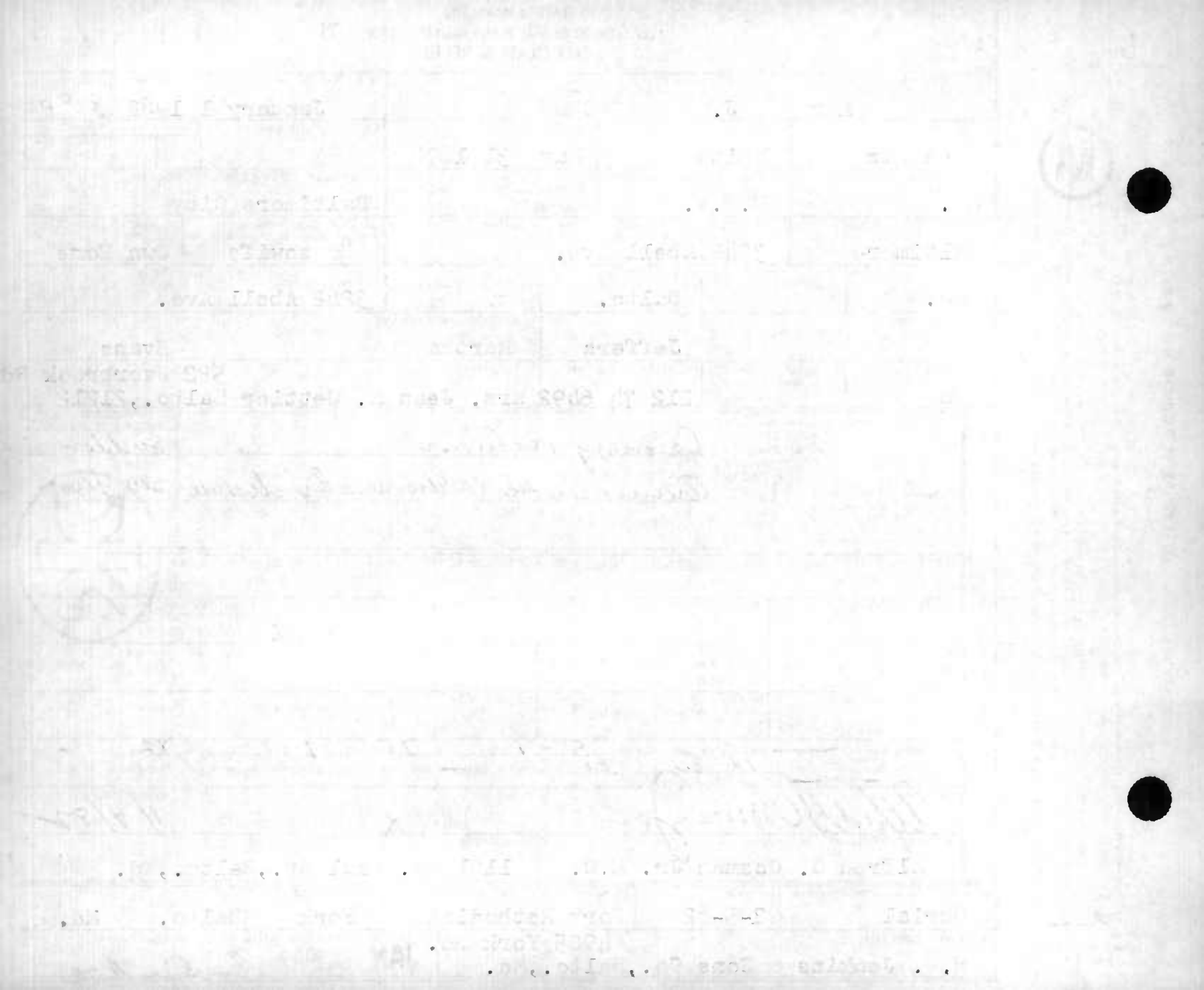


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |  |   | REG. NO. 8 2 0 1 4 7 5   |  |
|--|--|---|--|---|--|---|--|--|---|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  |   |  |   |  |  |   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>May J. SENNER  |  |   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>January 1 1982  |  |  | 2b. HOUR<br>8 <sup>30</sup> P.M.              |  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>May 31 1898  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>83 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |   | IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3242 Abell Ave. |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                      |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home |  |  |
| 13a. STATE<br>Md.  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Balto.   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>3242 Abell Ave.   |   |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Jeffers   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Martha Evans  |  |   |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>212 74 6492   |  | 17. INFORMANT ADDRESS<br>Mrs. Jean M. Gettier Balto., 21212 522 Overbrook Rd  |  |   |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary occlusion</u><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic cardiovascular disease</u><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Sudden</u><br><u>sev. years.</u> |  |   |  |   |  |   |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |  |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5-1</u> , 19 <u>75</u> , to <u>1-1</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>12-30</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br><u>Alfred G. Ossman Jr.</u>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br><u>1/4/82</u>  |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Alfred G. Ossman Jr. M.D.   |  |   |  | 22e. ADDRESS<br>1101 St. Paul St., Balto., Md.  |  |   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |   |  | 23b. DATE<br>1-5-82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Fork Methodist  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Fork Balto. Md.                           |   |  |  |
| 24. FUNERAL DIRECTOR NAME<br>H.W. Jenkins & Sons Co., Balto., Md.  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 4 1982   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>                                     |   |  |  |





## CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |   |  |   |   |   |   |  |  |  |  |
|---|--|---|--|---|---|---|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JOSEPHINE MARY SERIO</b>   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>1 21 82</b>                     |   |   | 2b. HOUR<br><b>4:50</b> M   |   |  |  |  |  |
| 3. SEX<br><b>F</b>  |  | 4. RACE<br><b>W</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 9 1907</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b> YRS.                                     |   | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>OHIO</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>CITY</b> MD.                               |   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>S. BALTO GEN HOSP</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOME MAKER</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b>  |  |   | 13b. COUNTY<br><b>-</b>  |   | 13c. CITY OR TOWN<br><b>BALTO</b>         |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1544 NORTHGATE RD</b>          |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>FRANK - SERIO</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary UNK</b>  |   |   |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  |   | 16b. SOCIAL SECURITY NO.<br><b>UNK 218-32-3591</b>                     |   | 17. INFORMANT<br><b>Christine Burrows</b> |   | ADDRESS<br><b>Fanceen &amp; Fanceen</b>   |  | 2233 World Trade Center                                  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>MYOCARDIAL INFARCT/OR ARRHYTHMIA</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) <b>ASCVD</b><br>DUE TO, OR AS A CONSEQUENCE OF |  |   |  |   |   |   |   |  |  | APPROXIMATE PERIOD BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |   |   |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)        |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                     |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/18/82</b> to <b>1/21/82</b> , that (I) (we) last saw the deceased alive on <b>1/21/82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |   |   |   |  |  |  |  |
| 22b. SIGNATURE<br><b>C. ZIGEL</b>   |  |   |  |   |   | DEGREE<br><b>MD</b>   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1/21/82</b>         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>C. ZIGEL</b>  |  |   |  |   |   | 22e. ADDRESS<br><b>3001 S. HANOVER ST</b>   |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Removal</b>   |  |   | 23b. DATE<br><b>1/23/82</b>  |   |   | 23c. NAME OF CEMETERY OR CREMATORY  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE               |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Anatomy Board</b>  |  |   |  |   |   | ADDRESS<br><b>Balto., Md.</b>   |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 1 1982</b>       |  |  |
|   |  |   |  |   |   |   |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Frances Jean Nathan</b> |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 8 2 0 1 4 7 7   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1- FOR STATE REGISTRAR  |  |  |  | REG. NO.  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>OREGON R Sewell</b>  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 31 82</b>   |  | 2b. HOUR<br><b>9 10 P M</b>   |  |
| 3. SEX<br><b>M</b>  |  | 4. RACE<br><b>B</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 27 08</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>S. C.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO CITY</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNIV OF MD HOSP.</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>UNKNOWN</b>   |  |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>BALTO</b>  |  | 13c. CITY OR TOWN<br><b>BALTO</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>WILLIAM SEWELL</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>LILA LOMAX</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>183-16-5721</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Helen R. Sewell 2722 Bookert Drive</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b><br><b>2021</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>DIFFUSE HISTIOCYTIC LYMPHOMA</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <b>MYCOSIS FUNGOIDES</b> |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>IMMEDIATE</b><br><b>1 month</b><br><b>YEARS</b>                                    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION<br><b>—</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>—</b>   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>— P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>—</b>   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>—</b>   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>— BALTO MD</b>  |  |   |  |
| 22a. I certify that (this hospital) attended the deceased from <b>1/31 82</b> , to <b>1/31 82</b> , that (we) last saw the deceased alive on <b>1/31 82</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (not) view the body after death.   |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Edward J. Lee</b>  |  |  |  | DEGREE<br><b>—</b>  |  | 22c. DATE SIGNED<br><b>1/31/82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>EDWARD J. LEE, MD</b>   |  |  |  | 22e. ADDRESS<br><b>22 S. GREENE ST., BALTO, MD</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>2/6/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Meadow Ridge Cem.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co. MD</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 2 1982</b>  |  |   |  |
| ADDRESS<br><b>1101 E. North Ave.</b>  |  |  |  | REGISTRAR'S SIGNATURE<br><b>—</b>   |  |   |  |

Don't forget to check the box for the correct answer.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 4 7 8

REG. NO.

|  |   |  |   |  |
|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Josephine M. Shasahan   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>01 31 82  |   | 2b. HOUR<br>7 <sup>20</sup> P.M.   |
| 3. SEX<br>F  | 4. RACE<br>Cauc.  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>03 24 10   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>71 YRS.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Balto. City MD                               |
| 10. CITY OR TOWN OF DEATH<br>Balto.  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University of Maryland Hosp. |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY<br>at Home   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.  |   | 13b. COUNTY<br>BALTO   | 13c. CITY OR TOWN<br>Balto.   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Thomas   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Rose Ma Gee   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>UNK  |   | 16b. SOCIAL SECURITY NO.<br>216-05-3694  |   | 17. INFORMANT<br>ADDRESS<br>chart - husband  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) cardiopulmonary arrest<br>4149<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br>Coronary Artery disease, Right lung pneumonia   |   |  |   |  |
| 19a. DATE OF OPERATION<br>None   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   |  |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   | 22a. CERTIFY THAT (I) (this hospital) attended the deceased from 1/28 19 82, to 1/31 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. |   |  |
| 22b. SIGNATURE<br>Robert Fuld MD   |   | DEGREE   |   | 22c. DATE SIGNED<br>2/31/82  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ROBERT FULD, MD   |   | 22e. ADDRESS<br>UNIVERSITY HOSPITAL  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   | 23b. DATE<br>2/4/82   | 23c. NAME OF CEMETERY OR CREMATORY<br>New Cathedral  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO MD                        |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>EVANS FUNERAL CHAPEL   |   | 25a. DATE REC'D. BY REGISTRAR<br>FEB 4 1982  |   | 25b. REGISTRAR<br>Francis J. [Signature]   |

MEDICAL CERTIFICATION

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FEB 4 1955

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Payment may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director must detach it for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file them in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO. 8201479  |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  | 20. DATE OF DEATH MONTH DAY YEAR  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Joseph S. Shanley   |  |  |  | 20. Jan 13, 1982  |  |  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>11-20-08   |  | 2b. HOUR<br>1:40P  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>73 YRS   |  | 7. IF UNDER 1 YEAR MONTHS DAYS   |  | 8. IF UNDER 24 HRS. HOURS MIN.  |  |  |  |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>The Johns Hopkins Hospital |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Electrician  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Bechtel Contractor  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. COUNTY<br>Pennsylvania   |  | 13d. CITY OR TOWN<br>DelTA   |  | 13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13f. STREET ADDRESS<br>Box 319 Route 1   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>John T. Shanley  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>MARY AGNES DRISCOLL   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>Yes  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>WW II  |  | 17. INFORMANT<br>John T. Shanley  |  | 17. ADDRESS<br>1447 Lowman Street  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 1629 CARDIAC ARREST<br>DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC RESPIRATORY FAILURE<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>30 MIN<br>2 MINS  |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a)<br>SMALL CELL BRONCHOGENIC CANCER   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION<br>11-20-81  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Lung Cancer  |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (1) this hospital attended the deceased from 11-18-81 to 1-13-82, that (2) I saw the deceased alive on 1-13-82, and that in my (a) opinion death occurred on the date and hour and from the causes stated above (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) (11) (12) (13) (14) (15) (16) (17) (18) (19) (20) (21) (22) (23) (24) (25) (26) (27) (28) (29) (30) (31) (32) (33) (34) (35) (36) (37) (38) (39) (40) (41) (42) (43) (44) (45) (46) (47) (48) (49) (50) (51) (52) (53) (54) (55) (56) (57) (58) (59) (60) (61) (62) (63) (64) (65) (66) (67) (68) (69) (70) (71) (72) (73) (74) (75) (76) (77) (78) (79) (80) (81) (82) (83) (84) (85) (86) (87) (88) (89) (90) (91) (92) (93) (94) (95) (96) (97) (98) (99) (100) (101) (102) (103) (104) (105) (106) (107) (108) (109) (110) (111) (112) (113) (114) (115) (116) (117) (118) (119) (120) (121) (122) (123) (124) (125) (126) (127) (128) (129) (130) (131) (132) (133) (134) (135) (136) (137) (138) (139) (140) (141) (142) (143) (144) (145) (146) (147) 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SECRET

Handwritten notes and signatures, mostly illegible due to fading and bleed-through. Some visible words include "SECRET", "CONFIDENTIAL", and "TOP SECRET".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 8 2 0 1 4 8 0   |  |   |   |
|--|--|--|--|---|--|---|---|
| 1. FOR<br>STATE<br>REGISTRAR   |  |  |  | REG. NO.  |  |   |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>C. Morgan Sharff  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>January 9, 1982  |  |   |   |
| 3 SEX<br>Male  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>March 3, 1910   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>71   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>City MD   |   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore City Hospital |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Accountant  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |   |
| 13a. STATE<br>Md.  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                               |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Ernest Sharff  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Katherine Snowden   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES<br>no  |  |   |   |
| 16b. SOCIAL SECURITY NO.<br>214-01-9237  |  | 17. INFORMANT ADDRESS<br>Mrs. Carol Diegelman 303 Cass Ct. Balair, Md.   |  |   |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u><br>1850<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Prostatic Carcinoma</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) |  |  |  |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |   |
| 22b. SIGNATURE<br>D. Siegel  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br>1/9/82  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>D. Siegel   |  |  |  | 22e. ADDRESS<br>Balt City Hosp  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>Jan. 12, 1982   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Druid Ridge   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Pikesville Balto. Md.   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Leonard J. Ruck Inc. Baltimore, Maryland   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 11 1982  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]   |   |

THE UNIVERSITY OF CHICAGO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 4 8 1

REG. NO.

|   |  |  |  |  |   |  |   |   |   |
|---|--|--|--|--|---|--|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ALAN P. SHARMAN, SR.</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 23 82</b>                  |  |   | 2b. HOUR<br><b>4:45 P.M.</b>   |   |   |   |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 29 17</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b>   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>YRS.</b>  |   |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 9. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 11. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |   |   |   |
| 12. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Agnes Hospital</b> |  |  |   | 14. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Police</b>   |   | 15. KIND OF BUSINESS OR INDUSTRY<br><b>Penn Central</b>   |   |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  |  | 13b. CITY OR TOWN<br><b>Baltimore</b>                                  |  | 13c. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 13d. STREET ADDRESS<br><b>2761 Yarnall Road 21227</b> |   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Harry Sharman</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Myrtle Preston</b> |  |   |  |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>WW II 215-05-6222</b>   |  | 17. INFORMANT ADDRESS<br><b>Alan P. Sharman 12601 Sturdee Drive 20870</b>  |   |  |   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4149 RECURRENT CARDIAC ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br><b>ESTABLISHED CORONARY DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br><b>CHRONIC MYOCARDIAL INFARCTION</b>  |  |  |  |  |   |  |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a<br><b>CHRONIC MYOCARDIAL INFARCTION</b>  |  |  |  |  |   |  |   |   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |   |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |   |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/23/82</b> 19 <b>82</b> to <b>1/25/82</b> 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>NOT ALIVE</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |   |  |   |   |   |
| 22b. SIGNATURE<br><b>John J. Patterson</b>  |  |  |  | DEGREE<br><b>MD</b>  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/><br>DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>1/25/82</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>John J. Patterson</b>   |  |  |  | 22e. ADDRESS<br><b>St. Agnes Hospital 900 Catoctin Ave</b>   |   |  |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>1/27/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Crest Lawn Mem. Gar.</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Marriottsville Howard Md.</b>   |   |   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Hubbard Funeral Home, Inc.</b>   |  |  |  | 24b. ADDRESS<br><b>4107 Wilkens Ave.</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 27 1982</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Frances Jean Nathan</b>  |   |

STATE OF NEW YORK

IN SENATE  
January 1, 1902

| NAME          | RESIDENCE | EDUCATION     | EXPERIENCE | REMARKS |
|---------------|-----------|---------------|------------|---------|
| JOHN J. HENRY | NEW YORK  | B.A. COLUMBIA | 10 YEARS   |         |
| JOHN J. HENRY | NEW YORK  | B.A. COLUMBIA | 10 YEARS   |         |
| JOHN J. HENRY | NEW YORK  | B.A. COLUMBIA | 10 YEARS   |         |
| JOHN J. HENRY | NEW YORK  | B.A. COLUMBIA | 10 YEARS   |         |
| JOHN J. HENRY | NEW YORK  | B.A. COLUMBIA | 10 YEARS   |         |
| JOHN J. HENRY | NEW YORK  | B.A. COLUMBIA | 10 YEARS   |         |
| JOHN J. HENRY | NEW YORK  | B.A. COLUMBIA | 10 YEARS   |         |
| JOHN J. HENRY | NEW YORK  | B.A. COLUMBIA | 10 YEARS   |         |
| JOHN J. HENRY | NEW YORK  | B.A. COLUMBIA | 10 YEARS   |         |
| JOHN J. HENRY | NEW YORK  | B.A. COLUMBIA | 10 YEARS   |         |



JOHN J. HENRY, NEW YORK, B.A. COLUMBIA, 10 YEARS. JAN 27 1902. STATE OF NEW YORK.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 4 8 2

REG. NO.

|  |  |  |   |  |  |   |  |  |  |  |  |
|--|--|--|---|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Ella A. Sharpe  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1 21 1982                      |  |  | 2b. HOUR<br>M   |  |  |  |  |  |
| 3 SEX<br>female  |  | 4 RACE<br>black  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>6 30 10  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>71 YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Portsmouth, VA  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore city MD.                                       |  |  |  |  |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1912 E. 31st Street |   |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  |  | 12b. KIND OF BUSINESS OR INDUSTRY          |  |  |
| 13a. STATE<br>Md   |  |  | 13b. COUNTY<br>Baltimore  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET ADDRESS<br>1912 E. 31st Street |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>James Barnes   |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Maggie Anderson   |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No   |  |  |   | 16b. SOCIAL SECURITY NO.<br>227-26-8874  |  | 17 INFORMANT ADDRESS<br>Carolyn Jolley 1912 E. 31st Street                                      |  |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Probable myocardial infarction</u><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>Hypertension</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>arteriosclerotic cardiovascular disease</u> |  |  |   |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>immediate</u><br><u>yes</u><br><u>yes</u> |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Peripheral vascular disease</u>   |  |  |   |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                      |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19            |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><u>Donald J Weglein</u><br>DEGREE <u>MD</u><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>   |  |  |   |  |  | 22c. DATE SIGNED<br><u>1/21/82</u>  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>WEGLEIN</u>  |  |  |   |  |  | 22e. ADDRESS<br><u>Union Memorial Hosp.</u>   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |  | 23b. DATE<br>1/25/82  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore Cemetery |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. _____ MD  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>William C. March F/H 1101 E. North Avenue  |  |  |   |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 22 1982  |  |  |  |  |  |

JAN 23 1963



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 4 8 3

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |   |  |
|--|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>PEAR E Shelton</b>  |  |   | 2a. DATE OF DEATH<br>MONTH <b>1</b> DAY <b>28</b> YEAR <b>82</b> 2b. HOUR <b>2:10</b> P.M.      |  |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH <b>1</b> DAY <b>29</b> YEAR <b>16</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>65</b> YRS                                     |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. City</b> MD.                       |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO.</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Agnes Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Data Processor</b>       | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Westinghouse</b>                             |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD.</b> 13b. COUNTY <b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Lansdowne</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br><b>15 5th Avenue</b> 21227                                    |
| 14. FATHER'S NAME<br>FIRST <b>Thomas</b> MIDDLE <b>H.</b> LAST <b>Chance</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Anna</b> MIDDLE <b>Chambers</b>  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>215-03-2329</b>  |   | 17. INFORMANT<br><b>Rosemary E. Miller</b> ADDRESS<br><b>135 Hazel Avenue 21227</b>  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>MYOCARDIAL INFARCTION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>RENAL FAILURE</b>   |  |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a  |  |   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/12</b> , 19 <b>82</b> , to <b>1/28</b> , 19 <b>82</b> , that (h) (we) lost<br>saw the deceased alive on <b>1/28</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |   |  |
| 22b. SIGNATURE<br><b>Geetha Rajar</b>  |  | DEGREE<br><b>Resident</b>   |   | 22c. DATE SIGNED<br><b>1/28/82</b>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>GEETHA RAJA</b>  |  | 22e. ADDRESS<br><b>ST. Agnes Hospital</b>   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>   |  | 23b. DATE<br><b>2/1/82</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral Cem.</b>                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>              |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Hubbard Funeral Home, Inc.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 29 1982</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><i>James J. Nathan</i>                                 |

MEDICAL CERTIFICATION



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 4 8 4

FOR  
1. STATE  
REGISTRAR

REG. NO.

|  |  |   |   |  |   |  |   |   |   |  |
|--|--|---|---|--|---|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>BABY GIRL SHERWOOD  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>01 17 82                     |  |   | 2b. HOUR<br>936 PM   |   |   |   |  |
| 3 SEX<br>FEMALE  |  | 4 RACE<br>BLACK   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>07 12 81   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br>6 5                           |   | IF UNDER 1 YEAR<br>IF UNDER 24 HRS.<br>HOURS MIN.   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>USA   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>     |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                           |   |   |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE MD.   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNIVERSITY & MD HOSPITAL |   |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     |   | 12b. KIND OF BUSINESS OR INDUSTRY   |   |  |
| 13a. STATE<br>MD Md.   |  |   | 13b. COUNTY<br>BALT.  |  | 13c. DISTRICT<br>BALT.                            |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br>217 South St., 21601 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>KEITH - SHERWOOD   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>VANESSA R SHERWOOD |  |   |  |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  |   | 16b. SOCIAL SECURITY NO.<br>-                                       |  | 17. INFORMANT ADDRESS<br>DR BERMAN UNIV. HOSPITAL |  |   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>4275 IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |   |   |  |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br>PREMATURITY, BROWNOPULMONARY DYSPLASIA, MULT. CONGENITAL ANOMALIES   |  |   |   |  |   |  |   |   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART I OR PART 2)   |   |  |   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |   |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/12, 19 81, to 1/17, 19 82, that (I) (we) last saw the deceased alive on 1/17, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |  |   |  |   |   |   |  |
| 22b. SIGNATURE<br>ERIC D BERMAN  |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |  |   | 22c. DATE SIGNED<br>1/17/82   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ERIC D BERMAN   |  |   |   | 22e. ADDRESS<br>UNIVERSITY OF MARYLAND HOSPITAL  |   |  |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Removal  |  | 23b. DATE<br>1/28/82  |   | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |   |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Anatomy Board  |  |   |   | ADDRESS<br>Balto., Md.   |   | 25a. DATE REC'D. BY REGISTRAR<br>FEB 1 1982  |   | 25b. REGISTRAR'S SIGNATURE<br>Charles J. Van Wagoner  |   |  |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |   |  | REG. NO. 2 0 1 4 8 5  |  |
|--|--|--|--|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  |  |  |   |  |   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Walter HAMILTON Shields  |  |  |  |  |  |   |  |   |  | 2a. DATE OF DEATH KNOWN <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR<br>1 17 19 82 |  |
| 3. SEX<br>Male   |  | 4. RACE<br>Black                         |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 28 19 05   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>76 YRS.  |  | IF UNDER 1 YR. MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>1 17 19 82  |  |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  | 7c. CITIZEN OF WHAT COUNTRY?<br>U. S. A. |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>701 W. Lanvale Street |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>MAINTENANCE  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>HILL ASSOCIATES  |  |
| 13a. STATE<br>MARYLAND   |  |  |  | 13b. COUNTY<br>BALTIMORE   |  | 13c. CITY OR TOWN<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>13e. STREET ADDRESS<br>701 W. LANVALE ST. BALTIMORE, MARYLAND 21217 |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>RICHARD SHIELDS   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>CURA HARRIS  |  |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br>NO   |  |  |  | 16b. SOCIAL SECURITY NO.<br>219-30-7981  |  | 17. INFORMANT<br>BALTIMORE  |  |   |  | ADDRESS<br>MARYLAND 21217   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease<br>4292<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |  |  |  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |  |  |  |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE<br>Virginia L. Dolan  |  |  |  | TITLE (SPECIFY)<br>M.D. Assistant  |  |   |  | DATE SIGNED<br>1-17-82  |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Virginia L. Dolan, M.D.   |  |  |  | ADDRESS<br>111 Penn Street   |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |  |  | 23b. DATE<br>1-22-82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>ARBUS MEMORIAL PARK   |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE COUNTY, MARYLAND  |  |
| 24. FUNERAL DIRECTOR NAME<br>HERBERT E. NATHAN   |  |  |  | ADDRESS<br>BALTIMORE MARYLAND 21216  |  | 25a. DATE RECD. BY REGISTRAR<br>JAN 20 1982   |  | 25b. REGISTRAR'S SIGNATURE<br>Francis J. Nathan   |  |   |  |

NO. 100



FILED IN

100



100 100 100 100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMM-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 4 8 6

REG. NO.

1. FOR  
STATE  
REGISTRAR

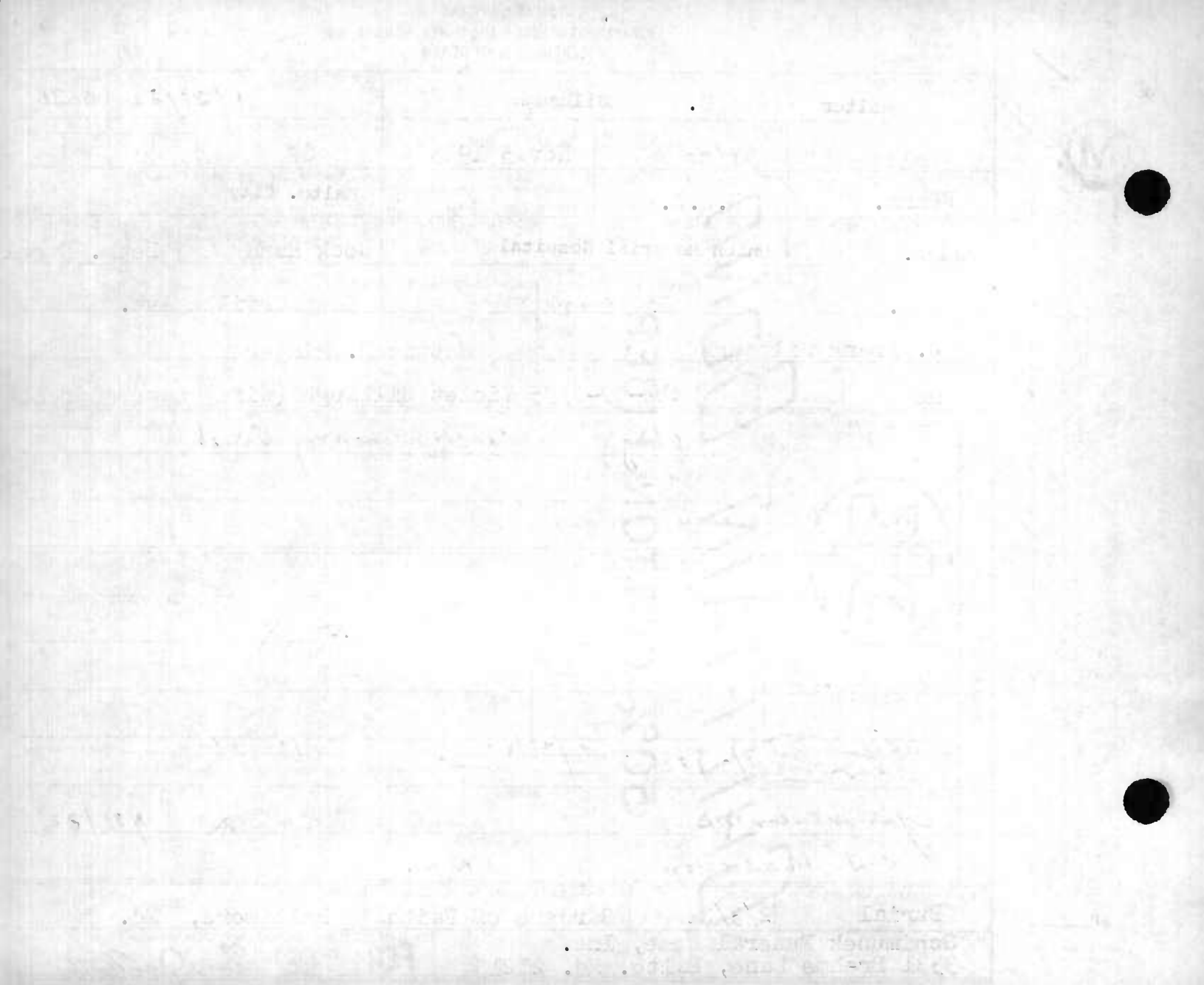
|   |  |   |   |   |  |
|---|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Walter C. Silbaugh   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>1/31/82   |   | 2b. HOUR<br>0630 M   |
| 3. SEX<br>Male  | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Nov 5 1913  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>68 YRS.  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Penna.   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Balto. City MD.   |   |  |
| 10. CITY OR TOWN OF DEATH<br>Balto.   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Union Memorial Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Dock Hand                   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Beth. Steel  |  |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |   |   |  |
| 13a. STATE<br>Md.   | 13b. COUNTY  | 13c. CITY OR TOWN<br>Baltimore  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>5088 Orville Ave.  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>J. Frank Silbaugh   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mattie B. Ringer                               |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>no  |  | 16b. SOCIAL SECURITY NO.<br>211-09-8595   | 17. INFORMANT<br>ADDRESS<br>Violet Silbaugh (wife) same address                                 |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Lung Ca - Cardiopulmonary Arrest</u><br>1629<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a) _____  |  |   |   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/21/82</u> , 19____, to <u>1/31/82</u> , 19____, that (I) (we) lost saw the deceased alive on <u>1/30/82</u> , 19____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)   |  |   |   |   |  |
| 22b. SIGNATURE<br><u>C. J. Huddleston MD.</u>   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |   | 22c. DATE SIGNED<br><u>1/31/82</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>C. J. Huddleston   |  | 22e. ADDRESS<br>UMH.  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>2/3/82   | 23c. NAME OF CEMETERY OR CREMATORY<br>Gardens of Faith  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Md.   |
| 24. FUNERAL DIRECTOR OR REGISTRAR<br>Schmuck Funeral Home, Inc.<br>3331 Brehms Lane, Balto. Md. 21213   |  |   | 25a. DATE REC'D. BY REGISTRAR<br>FEB 2 1982   |   | 25b. REGISTRAR'S SIGNATURE<br><u>Thomas J. North</u>   |

MEDICAL CERTIFICATION

29

2653 BP





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 22 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |                  |                |   |  |  |  |   |                 |  |  |   |  |   |                       |  |  |
|---|--|------------------|----------------|---|--|--|--|---|-----------------|--|--|---|--|---|-----------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |                  | FIRST<br>Glenn |   |  | MIDDLE<br>O.   |  |   | LAST<br>Simmons |  |  | 2a. DATE KNOWN<br>OF DEATH<br>ESTIMATED<br><input checked="" type="checkbox"/> MONTH DAY YEAR<br>1 23 19 82 |  |   | 2b. HOUR<br>M<br>5:43 |  |  |
| 3. SEX<br>male  |  | 4. RACE<br>white |                | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5 9 21  |  | 6. AGE (IN YEARS<br>LAST BIRTHDAY)<br>60 YRS.                |  | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.   |                 | 8. IF UNDER 24 HRS.  |  | 2c. DATE<br>PRONOUNCED<br>DEAD<br>1 23 19 82  |  |   | 2d. HOUR<br>5:43      |  |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)<br>West Virginia   |  |                  |                | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                 |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.  |  |   |                       |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  |                  |                | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore City Hospital |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)<br>Line Worker-General Motors  |                 |  |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY  |  |   |                       |  |  |
| 13a. STATE<br>Maryland  |  |                  |                | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Dundalk                                 |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                 | 13e. STREET ADDRESS<br>8260 Kavanagh Road                          |  |   |  |   |                       |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Olin G. Simmons   |  |                  |                |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Kate Harper |  |   |                 |  |  |   |  |   |                       |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>Yes  |  |                  |                | (IF YES, GIVE WAR OR DATES)<br>WW II  |  | 16b. SOCIAL SECURITY NO.<br>218-12-8054                      |  | 17. INFORMANT<br>ADDRESS<br>8260 Kavanagh Road<br>Rosietta Simmons Balto., MD. 21222  |                 |  |  |   |  |   |                       |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u><br>4292<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a) stating the under-<br>lying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF  |  |                  |                |   |  |  |  |   |                 |  |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |                       |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.   |  |                  |                |   |  |  |  |   |                 |  |  |   |  |   |                       |  |  |
| 19a. DATE OF OPERATION  |  |                  |                | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |   |                 |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                         |  |   |                       |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                  |                | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |                 |  |  |   |  |   |                       |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE<br>AT WORK <input type="checkbox"/>  |  |                  |                | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)  |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                 |  |  |   |  |   |                       |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion<br>death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                  |                |   |  |  |  |   |                 |  |  |   |  |   |                       |  |  |
| ACTUAL<br>SIGNATURE<br><i>Rosietta Simmons</i>  |  |                  |                | M.D. Assistant  |  |  |  | MEDICAL EXAMINER  |                 |  |  | DATE<br>SIGNED 1/24/82  |  |   |                       |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Margarita A. Korell, M.D.   |  |                  |                | ADDRESS 111 Penn Street, Baltimore, MD 21201  |  |  |  |   |                 |  |  |   |  |   |                       |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |                  |                | 23b. DATE<br>1/27/1982  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Holly Hill             |  |   |                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>White Marsh Maryland |  |   |  |   |                       |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Duda-Ruck, Inc.   |  |                  |                | ADDRESS<br>7922 Wise Avenue Dundalk, MD. 21222  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 29 1982  |                 |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Thomas J. [Signature]</i>  |  |   |                       |  |  |

100-38881-100

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 4 8 8

REG. NO.

|   |   |   |  |  |  |  |  |   |
|---|---|---|--|--|--|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |   |   | 2a. DATE OF DEATH  |  |  | 2b. HOUR   |  |   |
| FIRST MIDDLE LAST<br>BLANCHE SIMMS  |   |   | MONTH DAY YEAR<br>1 5 82   |  |  | 12 55 PM   |  |   |
| 3. SEX  | 4. RACE   | 5. DATE OF BIRTH  | 6. AGE (IN YEARS (LAST BIRTHDAY))                                      |  |  | 7. IF UNDER 1 YEAR   |  |   |
| Female  | Black   | MONTH DAY YEAR<br>12 3 1896   | 85   |  |  | MONTHS DAYS HOURS MIN.   |  |   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                   |  |  |  |  |   |
| MD  | U.S.A.  |   | BALTO. CITY MD.  |  |  |  |  |   |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)       |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |
| BALTIMORE   | UNION MEMORIAL HOSPITAL   |   |  |  |  |  |  |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |   |   |  |  |  |  |  |   |
| 13a. STATE  | 13b. COUNTY   | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?   |  |  | 13e. STREET ADDRESS  |  |   |
| MD  |   | Baltimore   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>    |  |  | 1217 Linworth Ave. Apt. 1A   |  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST                          |  |  |  |  |   |
| Joseph Simms  |   |   | Molly Conyers  |  |  |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |   |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)                |  |  | 17. INFORMANT ADDRESS  |  |   |
| No  |   |   | 213-14-2434  |  |  | Frances France 1217 Linworth Ave. #1A  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY APRES</u><br>4100 DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>PROBABLE MI, ELECTRO-MECHANICAL</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>S/P ANTERIOR, SEMI</u><br>DISSOCIATION                                   |   |   |  |  |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>1 HOUR</u>  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><u>ASCVD, DIABETES</u>  |   |   |  |  |  |  |  |   |
| 19a. DATE OF OPERATION  |   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH? |
|   |   |   |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                                       |  | YES <input type="checkbox"/> NO <input type="checkbox"/>          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/29</u> , 19 <u>81</u> , to <u>1/5</u> , 19 <u>82</u> , that (I) (we) last<br>saw the deceased alive on <u>1/5</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |   |   | 22b. SIGNATURE<br>DEGREE<br><u>Vincent A. DiPietro MD</u>              |  |  | 22c. DATE SIGNED<br><u>1/5/82</u>  |  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |   |   | 22e. ADDRESS   |  |  |  |  |   |
| VINCENT A. DIPIETRO   |   |   | UNION MEMORIAL HOSP  |  |  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |   |   | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |   |
| Burial  |   |   | 1/9/82   |  | Baltimore Cemetery   |  | Baltimore MD                               |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H, Inc. 1101 E. North Ave.   |   |   |  |  |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br>JAN 7 1982 <u>Thomas J. Kaiter</u> |  |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |                            |   |   |  |  |  |  | 8 2 0 1 4 8 9  |  |
|---|--|---|----------------------------|---|---|--|--|--|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | REG. NO.  |                            |   |   |  |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ELMER. MILTON SINGER</b>   |  |   |                            |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 2 82</b>                  |  |  | 2b. HOUR<br><b>640 A</b>   |  |  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>CAUCASIAN</b>   |                            | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 4 14</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67 YRS</b>                               |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |                            | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.              |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN BALTIMORE CITY, STATE OF MARYLAND)<br><b>SINAI HOSPITAL</b> |                            |   |   | 12a. USUAL OCCUPATION<br>(TYPE AND NATURE OF WORKING (IFE))<br><b>MERCHANT</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>RETAIL</b>   |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>BALTIMORE</b>   |                            | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 13d. STREET ADDRESS<br><b>2901 TERRY DR. (APT. E. (21209))</b>                 |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>BENJAMIN SINGER</b>  |  |   |                            | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>SARAH LIPSEY</b>  |   |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>   |  |   |                            | 16b. SOCIAL SECURITY NO.<br><b>218-12-2976A</b>   |   | 17. INFORMANT ADDRESS<br><b>MRS. SARAH SINGER 2901 TERRY DR. (21209)</b>       |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Malignant Cardiac Arrhythmia → ARREST.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CORONARY Inefficiency:</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |                            |   |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)  |  |   |                            |   |   |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |   |                            | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |                            | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2) |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |   |                            | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12-29-81</b> , 19____, to <b>1-2-82</b> , 19____, that (I) (we) last saw the deceased alive on <b>1-2-82</b> , 19____ <b>6AM</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                     |  |   |                            |   |   |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Dspatel.</b>   |  |   |                            | DEGREE<br><b>MD.</b>  |   |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1-2-82.</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>D. S. PATEL.</b>  |  |   |                            | 22e. ADDRESS<br><b>SINAI HOSPITAL</b>   |   |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  |   | 23b. DATE<br><b>1-3-82</b> |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ADATH ISRAEL ANSHE SFARD</b> |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MD.</b>   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS. Inc.</b>  |  |   |                            |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 7 1982</b>                             |  |  |  |  |  |
| 6010 REISTERSTOWN RD. BALTIMORE MD, (21215)   |  |   |                            |   |   | REGISTERED BY<br><b>James J. Nathan</b>  |  |  |  |  |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN YOUR FILES AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |  |  |  |  |   |  |  |  |  |  |  |  |  |   |  |  |  |  |  |   |  |  |                        |  |  |
|---|--|--|--|--|--|---|--|--|--|--|--|--|--|--|---|--|--|--|--|--|---|--|--|------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  | FIRST<br>Julius  |  |  | MIDDLE<br>Singer  |  |  | LAST<br>Singer   |  |  | 20. DATE KNOWN OF DEATH<br>ESTIMATED                             |  |  | XX MONTH<br>1   |  |  | DAY<br>4   |  |  | YEAR<br>19 82                                     |  |  | 2b. HOUR<br>M<br>3:35A |  |  |
| 3. SEX<br>male  |  |  | 4. RACE<br>white   |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>APR. 2, 1910  |  |  | 6. AGE (IN YEARS<br>(LAST BIRTHDAY)<br>71 YRS.                         |  |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN                          |  |  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>1 4 19 82                             |  |  | 2d. HOUR<br>M<br>3:35A   |  |  |   |  |  |                        |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>LITHUANIA  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD              |  |  |  |  |  |   |  |  |  |  |  |   |  |  |                        |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Agnes Hospital |  |  |   |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>PROPRIETOR         |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>MEN'S CLOTHING  |  |  |   |  |  |                        |  |  |
| 13a. STATE<br>MARYLAND  |  |  |  |  |  |   |  |  |  |  |  |  |  |  | 13b. CITY OR TOWN<br>BALTO.   |  |  | 13c. INSIDE CITY LIMITS<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  | 13d. STREET ADDRESS<br>3406 OLD FOREST RD. #21208 |  |  |                        |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>YALE ISAAC SINGER   |  |  |  |  |  |   |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ETHEL JENNIE MELMAN                |  |  |  |  |  |   |  |  |                        |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>YES  |  |  | (IF YES, GIVE WAR OR DATES)<br>WWII  |  |  | 16b. SOCIAL SECURITY NO.<br>213-10-5696   |  |  | 17. INFORMANT<br>EDWIN SINGER ADDRESS<br>6432 ELRAY DR., APT. A #21209 |  |  |  |  |  |   |  |  |  |  |  |   |  |  |                        |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Multiple injuries<br>8120<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c) DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |   |  |  |  |  |  |   |  |  |                        |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |  |  |  |  |   |  |  |  |  |  |  |  |  |   |  |  |  |  |  |   |  |  |                        |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |   |  |  |  |  |  |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  |   |  |  |                        |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>6:14PM 12/30/81   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>driver in auto/auto collision  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |   |  |  |                        |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>street  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>I-95 South of I695, Arbutus, Balto Co., MD   |  |  |  |  |  |  |  |  |   |  |  |  |  |  |   |  |  |                        |  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |  |  |  |  |   |  |  |  |  |  |  |  |  |   |  |  |  |  |  |   |  |  |                        |  |  |
| ACTUAL SIGNATURE<br>H. R. Shaw  |  |  | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER   |  |  |   |  |  |  |  |  |  |  |  | DATE SIGNED<br>1/4/82   |  |  |  |  |  |   |  |  |                        |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Hormez R. Guard, MD   |  |  | ADDRESS<br>111 Penn Street, Balto., MD 21201   |  |  |   |  |  |  |  |  |  |  |  |   |  |  |  |  |  |   |  |  |                        |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  |  | 23b. DATE<br>JAN. 5, 1982  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>BETH TFILOH   |  |  |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MARYLAND |  |  |   |  |  |  |  |  |   |  |  |                        |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>SOL LEVINSON & BROS., INC.  |  |  | ADDRESS<br>6010 REISTERSTOWN RD. BALTO., MD 21215  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 7 1982   |  |  | 25b. REGISTRAR'S SIGNATURE<br>Frances Van Natta                        |  |  |  |  |  |   |  |  |  |  |  |   |  |  |                        |  |  |

SECRET  
OFFICE OF THE SECRETARY OF DEFENSE  
WASHINGTON, D.C. 20301-6000



Handwritten signature or initials.

SECRET  
OFFICE OF THE SECRETARY OF DEFENSE  
WASHINGTON, D.C. 20301-6000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |  |  |   |   |  |   | 8  | 2 | 0   | 1                                 | 4   | 9 | 1   |  |  |
|--|--|--|--|--|--|---|---|--|---|--|---|---|-----------------------------------|---|---|---|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |  |  |  |  |   |   |  |   | REG. NO.   |   |   |                                   |   |   |   |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Geraldine</b> <b>Singleterry</b>  |  |  |  |  |  |   |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR 26 HOUR<br><b>1</b> <b>29</b> <b>82</b> <b>6:10 P</b> <b>M</b>  |   |   |                                   |   |   |   |  |  |
| 3. SEX<br><b>F</b>   |  |  | 4. RACE<br><b>B</b>  |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11</b> <b>9</b> <b>31</b>  |   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>51</b> YRS.                 |  |   | IF UNDER 1 YEAR<br>MONTHS DAYS  |                                   | IF UNDER 24 HRS.<br>HOURS MIN.  |   |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MO</b>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD. |  |   |   |                                   |   |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Sinai Hospital</b> |  |  |   |   |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |   |   | 12b. KIND OF BUSINESS OR INDUSTRY |   |   |   |  |  |
| 13a. STATE<br><b>Md.</b>   |  |  |  |  |  |   |   |  |   | 13b. COUNTY  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |                                   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>3701 Oakford Ave.</b> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James</b> <b>Bowman</b>   |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lillie</b> <b>Dingle</b> |   |   |  |   |  |   |   |                                   |   |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES OR UNKNOWN) <b>NO</b>   |  |  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES) <b>215-28-4241</b>   |   |   |  |   | 17. INFORMANT ADDRESS<br><b>Sharon Brown 1654 Ralworth Rd.</b>   |   |   |                                   |   |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Adenocarcinoma of the colon</b><br><b>1539</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |  |  |  |  |   |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>7 months</b>   |   |   |                                   |   |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____   |  |  |  |  |  |   |   |  |   |  |   |   |                                   |   |   |   |  |  |
| 19a. DATE OF OPERATION   |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   |   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                   |   |   |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M.</b> <b>19</b>     |   |   |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |   |                                   |   |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)       |   |   |  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |                                   |   |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1-29</b> , 19 <b>82</b> , to <b>1-21</b> , 19 <b>82</b> that (I) (we) lost<br>saw the deceased alive on <b>1-29</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |   |  |   |  |   |   |                                   |   |   |   |  |  |
| 22b. SIGNATURE<br><b>Lee Ann Roberts, M.D.</b>   |  |  |  |  |  |   |   |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>1-29-82</b>  |                                   |   |   |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Lee Ann Roberts, M.D.</b>  |  |  |  |  |  |   |   |  |   | 22e. ADDRESS<br><b>Sinai Hospital Baltimore, Md.</b>   |   |   |                                   |   |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |  |  |  | 23b. DATE<br><b>2/2/82</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem. Pk.</b> |  |   |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co. MD</b>   |                                   |   |   |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H</b>  |  |  |  |  |  |   |   |  |   | ADDRESS<br><b>1101 E. North Ave.</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 1 1982</b>  |                                   | 25b. REGISTRAR'S SIGNATURE<br><b>James J. Nathan</b>  |   |   |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |   |  |
|--|--|---|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |   |  | REG. NO. 8 2 0 1 4 9 2  |  |  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   |  | FIRST MIDDLE LAST   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR  |  | 2b. HOUR<br>a   |  |
| Ethel Lee SKEGGS   |  |   |  |   |  | January 8, 1982  |  | 10:20 AM  |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR  |  | 6. AGE<br>(IN YEARS LAST BIRTHDAY)   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS   |  |
| Female   |  | White   |  | April 30, 1943  |  | 88   |  |   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |   |  |
| Maryland   |  | U.S.A.  |  |   |  | Baltimore City MD.   |  |   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| Baltimore  |  | Maryland General Hospital   |  |   |  | housewife  |  | own home  |  |
| 13a. STATE   |  |   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| Maryland   |  |   |  | Baltimore   |  | Baltimore  |  | 13e. STREET ADDRESS   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |  |  |  |   |  |
| Thomas Poole   |  |   |  | Tabitha Baker   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   |  | 17. INFORMANT ADDRESS   |  |  |  |   |  |
| No   |  | 215-03-0397   |  | Gordon Skeggs 1406 Gibsonwood Rd. 21228   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br>4148<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Status post- Subendocardial Myocardial Infarction 1980</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>January 7</u> , 19 <u>82</u> , to <u>January 8</u> , 19 <u>82</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>January 8</u> , 19 <u>82</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (we) did not see the body after death.               |  |   |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><i>Joseph Ganey M.D.</i>   |  |   |  | DEGREE  |  |  |  | 22c. DATE SIGNED  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Joseph Ganey, M.D.  |  |   |  | 22e. ADDRESS<br>c/o Maryland General Hospital   |  |  |  | 1/8/82  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |   |  |
| Burial   |  | 1/11/82   |  | Pine Grove Cemetery   |  | Mt. Airy Frederick Md.   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS   |  |   |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |
| LEONARD & RUSSELL C. WITZKE FUNERAL HOMES<br>1630 Edmondson Avenue Baltimore Maryland 21228  |  |   |  | JAN 11 1982   |  | <i>James J. Witzke</i>   |  |   |  |

JAN 11 1955

JOHN J. ROBERTS, JR.  
1000 KENNEDY BLVD.  
BALTIMORE, MD. 21201

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BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

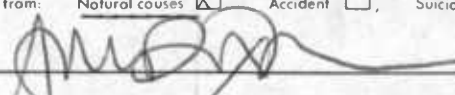
BP

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(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |                  |  |   |   |   |   |  |
|--|------------------|--|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>JOSEPH D. SLEEMAN</b>  |                  |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br>1 27 19 82 |   |   | 2b. HOUR<br>8:59<br>P M   |  |
| 3. SEX<br>male   | 4. RACE<br>white | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>May 18, 1916   | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br>65 YRS.   | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | IF UNDER 24 HRS.<br>HOURS MIN.  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>1 27 19 82                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                          |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>820 Cator Ave. |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)<br>Retired |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>U.S. Postal Dept. |
| 13a. STATE<br>Maryland   |                  | 13b. COUNTY<br>Baltimore   | 13c. CITY OR TOWN<br>Baltimore  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   | 13e. STREET ADDRESS<br>820 Cator Ave.                                   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Thomas Sleeman   |                  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Helen Flanagan                                       |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>Yes   |                  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>War II  |   | 17. INFORMANT ADDRESS<br>Mrs. Angela Sleeman, Baltimore, Md. Wife   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u><br>4292<br>(b) _____<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |                  |  |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH           |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |                  |  |   |   |   |   |  |
| 19a. DATE OF OPERATION   |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                  |  |   |   |   |   |  |
| ACTUAL SIGNATURE<br>  |                  | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER   |   |   |   | DATE SIGNED<br>1-28-82  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Ann M. Dixon, M.D.   |                  | ADDRESS<br>111 Penn St.  |   |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |                  | 23b. DATE<br>Feb. 1, 1982  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Sunset Memorial Park  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Cumberland, Allegany, Md.             |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>James F. Scarpelli, Cumberland, Md.  |                  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>FEB 3 1982   |   |   |  |

2 0 1 4 9 3





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  | REG. NO. 8 2 0 1 4 9 4 |  |  |  |  |  |   |  |   |  |                                |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|------------------------|--|--|--|--|--|---|--|---|--|--------------------------------|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR 1 26 82   |  |  |  |                        |  | 2b. HOUR 9 <sup>15</sup> A.M.  |  |  |  |   |  |   |  |                                |  |  |  |  |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Samuel S. Smalkin   |  |  |  |  |  | 3. SEX Male  |  |  |  |                        |  | 4. RACE Caucasian  |  | 5. DATE OF BIRTH MONTH DAY YEAR 10 13 06 |  | 6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS. |  | 7. IF UNDER 1 YEAR MONTHS DAYS  |  | 7. IF UNDER 24 HRS. HOURS MIN. |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND   |  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY? USA   |  |  |  |                        |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.   |  |                                |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH Baltimore  |  |  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital of Batt. |  |  |  |                        |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Attorney   |  |  |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY AT LAW  |  |                                |  |  |  |  |  |  |  |  |  |
| 13a. STATE Md.   |  |  |  |  |  | 13b. COUNTY Baltimore  |  |  |  |                        |  | 13c. CITY OR TOWN Baltimore  |  |  |  |   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |                                |  |  |  | 13e. STREET ADDRESS 3900 N. Charles St Apt 902 |  |  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST NATHAN SMALKIN   |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FANNIE SINGER   |  |  |  |                        |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO   |  |  |  |   |  | 16b. SOCIAL SECURITY NO. 213-05-6657  |  |                                |  |  |  | 17. INFORMANT MRS. GERTRUDE SMALKIN            |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrhythmias  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 minutes   |  |  |  |                        |  | 4100   |  |  |  |   |  | DUE TO, OR AS A CONSEQUENCE OF (b) Acute Myocardial Infarction  |  |                                |  |  |  | 13 days  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |  |  |  |  |  | DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerotic Heart Disease   |  |  |  |                        |  | 6 years  |  |  |  |   |  |   |  |                                |  |  |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Acute cerebrovascular Accident.  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |   |  |   |  |                                |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  |                        |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)  |  |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  |  |  |                        |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |   |  |   |  |                                |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  |  |                        |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |   |  |                                |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) <del>this hospital</del> attended the deceased from 1-13, 19 82, to 1-26, 19 82, that (I) <del>met</del> lost saw the deceased alive on 1-12, 19 82, and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>did not</del> view the body after death. |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |   |  |   |  |                                |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE Warren Israel MD  |  |  |  |  |  | DEGREE   |  |  |  |                        |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  |  |  |   |  | 22c. DATE SIGNED 1-26-82  |  |                                |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) WARREN Israel MD   |  |  |  |  |  | 22e. ADDRESS Ruxton Towers Ste 217 Batt, Md. 21204   |  |  |  |                        |  |  |  |  |  |   |  |   |  |                                |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL   |  |  |  |  |  | 23b. DATE JAN. 28, 1982  |  |  |  |                        |  | 23c. NAME OF CEMETERY OR CREMATORY HAR SINAI   |  |  |  |   |  | 23d. LOCATION OWINGS MILLS BALTO. MD  |  |                                |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC.  |  |  |  |  |  | 6010 REISTERSTOWN RD. BALTO., MD 21215   |  |  |  |                        |  | 25a. DATE REC'D. BY REGISTRAR FEB 2 1982   |  |  |  |   |  | 25b. REGISTRAR'S SIGNATURE Charles J. Smith   |  |                                |  |  |  |  |  |  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |   |   | 8 2 0 1 4 9 '5    |   |  |
|---|--|---|---|---|-------------------|---|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO.  |   |   |                   |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>(Alnetto) Almeta R. Smith   |  |   | 2. DATE OF DEATH MONTH DAY YEAR<br>1-2-82 |   | 2b. HOUR<br>10 PM |   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>Black  |   | 5. DATE OF BIRTH MONTH DAY YEAR<br>9-7-07   |                   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>UNKNOWN  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Balti. City MD  |  |
| 10. CITY OR TOWN OF DEATH<br>Balti City   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Lutheran Hosp of Md |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>None   |                   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br>Duke land Nsg Home  |  |   |   | 13b. COUNTY<br>Duke land Nsg Home   |                   | 13c. CITY OR TOWN   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Stillie Barnhill   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Addie Randolph  |   | 16. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                   | 17. STREET ADDRESS<br>1501 N Dukeland St.   |  |
| 18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 18b. SOCIAL SECURITY NO<br>?  |   | 19. INFORMANT ADDRESS<br>Lutheran Hosp of Md 730 Ashburton St.  |                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pneumonia</u><br>4360<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>CVA</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |   |   |   |                   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |   |   |                   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |                   |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |                   |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>12-07-81</u> to <u>1-2-82</u> , that (we) last saw the deceased alive on <u>12/28/81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (not) view the body after death.                                |  |   |   |   |                   |   |  |
| 22b. SIGNATURE<br>Sissps Ankle  |  | DEGREE<br>MD  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>       |                   | 22c. DATE SIGNED<br>1/2/82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Sissps Ankle   |  | 22e. ADDRESS<br>Lutheran Hospital   |   |   |                   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>1/7/82   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore Cemetery  |                   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore MD   |  |
| 24. FUNERAL DIRECTOR NAME<br>Wm. C. March F/H, Inc.   |  |   |   | 25a. DATE REC'D. BY REGISTRAR   |                   | 25b. REGISTRAR'S SIGNATURE  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The MICU requires that the death certificate be completed within 4 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 7 only should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |   |   |   |   |   |  |  |
|--|--|--|---|---|---|---|---|--|--|
| CERTIFICATE OF DEATH   |  |  |   |   |   |   |   |  |  |
| FOR<br>1 - STATE<br>REGISTRAR  |  |  |   |   | REG. NO.  |   |   |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Arthur Smith</b>  |  |  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>01/29/82</b>                      |   |   | 2b. HOUR<br><b>5:18P</b>   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Feb. 18, 1919</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>62</b> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD.</b>                               |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Johns Hopkins Hospital</b> |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Carpenter</b>            |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Construction</b>   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |   |   |   |   |   |  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>-</b>  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John William Smith</b>  |  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elizabeth A. Miller</b> |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>yes</b>   |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE YEAR OR DATES)<br><b>WWII 216 09 0955</b> |   | 17. INFORMANT<br>ADDRESS<br><b>Catherine A. Sweeney Same</b>                |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardio pulmonary arrest</b><br><b>4275</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Arterial brain injury</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>cardio pulmonary arrest</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |   |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>minutes</b><br><b>6 days</b><br><b>6 days</b>                           |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |   |   |   |   |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                    |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                          |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)              |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>1/23</b> , 19 <b>82</b> , to <b>1/29</b> , 19 <b>82</b> , that (we) lost saw the deceased alive on <b>1/29</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.   |  |  |   |   |   |   |   |  |  |
| 22b. SIGNATURE<br><b>Steven P. Schulman MD</b>   |  |  |   |   | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>1/29/82</b>  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Steven P. Schulman</b>   |  |  |   |   | 22e. ADDRESS<br><b>601 W Broadway Bldg 21205</b>                            |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>2-3-82</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith Cem.</b>          |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore County, Maryland</b> |  |  |
| 24. FUNERAL DIRECTOR<br><b>Grudzinski Funeral Home PA 1407 Old Eastern Ave.</b>  |  |  |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 1 1982</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>John J. [Signature]</b>   |  |

IT TO PPL & CHILD

514

411

*[Faint, illegible markings]*



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR A15 ME (5))  
15M2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |         |  |   |  |                                 |  |  |  |                  |  |   |  |  |  |   |  |  |  |                                   |  |  |  |       |  |  |  |          |  |
|--|--|---------|--|---|--|---------------------------------|--|--|--|------------------|--|---|--|--|--|---|--|--|--|-----------------------------------|--|--|--|-------|--|--|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST   |  | MIDDLE  |  | LAST                            |  | 2a. DATE KNOWN OF DEATH  |  |                  |  | ESTIMATED   |  |  |  | 3. MONTH  |  |  |  | DAY                               |  |  |  | YEAR  |  |  |  | 7b. HOUR |  |
| Bertha   |  | Smith   |  |   |  |                                 |  | 1  |  |                  |  | 21  |  |  |  | 1982  |  |  |  |                                   |  |  |  |       |  |  |  |          |  |
| 3. SEX   |  | 4. RACE |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY) |  | IF UNDER 1 YR.   |  | IF UNDER 24 HRS. |  | 7c. DATE PRONOUNCED DEAD  |  |  |  | MONTH   |  |  |  | DAY                               |  |  |  | YEAR  |  |  |  | 7d. HOUR |  |
| female   |  | black   |  | 3 10 22   |  | 59 YRS.                         |  |  |  |                  |  | 1   |  |  |  | 22  |  |  |  | 1982                              |  |  |  | 1:15  |  |  |  |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |         |  | 7b. CITIZEN OF WHAT COUNTRY?  |  |                                 |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |   |  |  |  |                                   |  |  |  |       |  |  |  |          |  |
| Georgia  |  |         |  | USA   |  |                                 |  |  |  |                  |  | Baltimore City  |  |  |  |   |  |  |  |                                   |  |  |  |       |  |  |  |          |  |
| 10. CITY OR TOWN OF DEATH  |  |         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                                 |  |  |  |                  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  |  |  |   |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |  |       |  |  |  |          |  |
| Baltimore  |  |         |  | 4311 Pillico Road   |  |                                 |  |  |  |                  |  |   |  |  |  |   |  |  |  |                                   |  |  |  |       |  |  |  |          |  |
| 13a. STATE   |  |         |  | 13b. COUNTY   |  |                                 |  | 13c. CITY OR TOWN  |  |                  |  | 13d. INSIDE CITY LIMITS?  |  |  |  | 13e. STREET ADDRESS   |  |  |  |                                   |  |  |  |       |  |  |  |          |  |
| Md.  |  |         |  |   |  |                                 |  | Balto.   |  |                  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  | 4311 Pimillico Rd.  |  |  |  |                                   |  |  |  |       |  |  |  |          |  |
| 14. FATHER'S NAME  |  |         |  |   |  |                                 |  | 15. MOTHER'S MAIDEN NAME   |  |                  |  |   |  |  |  |   |  |  |  |                                   |  |  |  |       |  |  |  |          |  |
| Bernard  |  |         |  |   |  |                                 |  | Ellen  |  |                  |  |   |  |  |  | Perry   |  |  |  |                                   |  |  |  |       |  |  |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |  |         |  | 16b. SOCIAL SECURITY NO.  |  |                                 |  | 17. INFORMANT ADDRESS  |  |                  |  |   |  |  |  |   |  |  |  |                                   |  |  |  |       |  |  |  |          |  |
| no   |  |         |  |   |  |                                 |  | Emily Randall 902 Belgian Ave.   |  |                  |  |   |  |  |  |   |  |  |  |                                   |  |  |  |       |  |  |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |         |  |   |  |                                 |  |  |  |                  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |  |  |                                   |  |  |  |       |  |  |  |          |  |
| PART I DEATH WAS CAUSED BY:  |  |         |  |   |  |                                 |  |  |  |                  |  |   |  |  |  |   |  |  |  |                                   |  |  |  |       |  |  |  |          |  |
| IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease  |  |         |  |   |  |                                 |  |  |  |                  |  |   |  |  |  |   |  |  |  |                                   |  |  |  |       |  |  |  |          |  |
| 4292   |  |         |  |   |  |                                 |  |  |  |                  |  |   |  |  |  |   |  |  |  |                                   |  |  |  |       |  |  |  |          |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |  |         |  |   |  |                                 |  |  |  |                  |  |   |  |  |  |   |  |  |  |                                   |  |  |  |       |  |  |  |          |  |
| (b)  |  |         |  |   |  |                                 |  |  |  |                  |  |   |  |  |  |   |  |  |  |                                   |  |  |  |       |  |  |  |          |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |         |  |   |  |                                 |  |  |  |                  |  |   |  |  |  |   |  |  |  |                                   |  |  |  |       |  |  |  |          |  |
| (c)  |  |         |  |   |  |                                 |  |  |  |                  |  |   |  |  |  |   |  |  |  |                                   |  |  |  |       |  |  |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1   |  |         |  |   |  |                                 |  |  |  |                  |  |   |  |  |  |   |  |  |  |                                   |  |  |  |       |  |  |  |          |  |
| 19a. DATE OF OPERATION   |  |         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |                                 |  |  |  |                  |  |   |  |  |  | 20. AUTOPSY?  |  |  |  |                                   |  |  |  |       |  |  |  |          |  |
|  |  |         |  |   |  |                                 |  |  |  |                  |  |   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |                                   |  |  |  |       |  |  |  |          |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |         |  | 21b. TIME OF INJURY   |  |                                 |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |                  |  |   |  |  |  |   |  |  |  |                                   |  |  |  |       |  |  |  |          |  |
|  |  |         |  | HOUR A.M. MONTH DAY YEAR  |  |                                 |  |  |  |                  |  |   |  |  |  |   |  |  |  |                                   |  |  |  |       |  |  |  |          |  |
|  |  |         |  | P.M. 19   |  |                                 |  |  |  |                  |  |   |  |  |  |   |  |  |  |                                   |  |  |  |       |  |  |  |          |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |  |         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |                                 |  | 21f. LOCATION  |  |                  |  | CITY OR TOWN  |  |  |  | COUNTY  |  |  |  | STATE                             |  |  |  |       |  |  |  |          |  |
|  |  |         |  |   |  |                                 |  |  |  |                  |  |   |  |  |  |   |  |  |  |                                   |  |  |  |       |  |  |  |          |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |         |  |   |  |                                 |  |  |  |                  |  |   |  |  |  |   |  |  |  |                                   |  |  |  |       |  |  |  |          |  |
| ACTUAL SIGNATURE   |  |         |  | TITLE (SPECIFY)   |  |                                 |  | DATE SIGNED  |  |                  |  |   |  |  |  |   |  |  |  |                                   |  |  |  |       |  |  |  |          |  |
| Margarita A. Korell, M.D.  |  |         |  | Assistant   |  |                                 |  | 1/23/82  |  |                  |  |   |  |  |  |   |  |  |  |                                   |  |  |  |       |  |  |  |          |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |  |         |  | ADDRESS   |  |                                 |  |  |  |                  |  |   |  |  |  |   |  |  |  |                                   |  |  |  |       |  |  |  |          |  |
|  |  |         |  | 111 Penn Street Baltimore, MD   |  |                                 |  |  |  |                  |  |   |  |  |  |   |  |  |  |                                   |  |  |  |       |  |  |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |         |  | 23b. DATE   |  |                                 |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |                  |  | 23d. LOCATION   |  |  |  | CITY OR TOWN  |  |  |  | COUNTY                            |  |  |  | STATE |  |  |  |          |  |
| Burial   |  |         |  | 1/29/82   |  |                                 |  | Mt. Calvary Cem.   |  |                  |  | Balto., Md.   |  |  |  |   |  |  |  |                                   |  |  |  |       |  |  |  |          |  |
| 24. FUNERAL DIRECTOR   |  |         |  |   |  |                                 |  |  |  |                  |  | 25a. DATE REC'D. BY REGISTRAR                                       |  |  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |                                   |  |  |  |       |  |  |  |          |  |
| LEROY O. DYETT 4600 LIBERTY HEIGHTS AVE.   |  |         |  |   |  |                                 |  |  |  |                  |  | FEB 1 1982  |  |  |  | Frances Jan Nathan  |  |  |  |                                   |  |  |  |       |  |  |  |          |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1. STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |                         |  |  |  |   |  |  |   |  |  |   |  |  |
|--|--|-------------------------|--|--|--|---|--|--|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Catherine A. Smith</b>   |  |                         | 2a. DATE OF DEATH<br>MONTH <b>1</b> DAY <b>30</b> YEAR <b>82</b>   |  |  | 2b. HOUR<br><b>7:30 A.M.</b>  |  |  |   |  |  |   |  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b> |  | 5. DATE OF BIRTH<br>MONTH <b>04</b> DAY <b>13</b> YEAR <b>1899</b> |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b> YRS  |  | 6. IF UNDER 1 YEAR<br>MONTHS <b>---</b> DAYS <b>---</b>  |   | 6. IF UNDER 24 HRS<br>HOURS <b>---</b> MIN <b>---</b>      |  |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD                                |  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  |                         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SOCIETY, GIVE STREET ADDRESS)<br><b>Jenkins Nursing Home<br/>1000 S. Caton Ave 21229</b> |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>---</b>   |  |  |   |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MARYLAND</b>   |  |                         | 13b. COUNTY <b>BALTIMORE</b>   |  |  | 13c. CITY OR TOWN <b>HALETHORPE</b>   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  | 13e. STREET ADDRESS<br><b>1810 PARK AVENUE, 21227</b> |  |  |
| 14. FATHER'S NAME<br>FIRST <b>EDWARD</b> MIDDLE <b>J.</b> LAST <b>MEEHAN</b>   |  |                         | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>MARY</b> MIDDLE <b>---</b> LAST <b>MEADE</b>  |  |  |   |  |  |   |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  |                         | 16b. SOCIAL SECURITY NO.<br><b>216-36-8724</b>   |  |  | 17. INFORMANT<br>ADDRESS <b>ELLCOTT CITY, MD.</b><br><b>CHARLES W. SMITH, JR. 3229 HEARTHSTONE RD.</b>  |  |  |   |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>4370 Occlusive arteriosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>cerebral vascular disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>---</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>---</b> |  |                         |  |  |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>---</b> |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><b>---</b>   |  |                         |  |  |  |   |  |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |  |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>---</b> P.M. <b>---</b> <b>19</b>  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |   |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |                         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1-30-82</b> to <b>1-30-82</b> that he (we) lost<br>saw the deceased alive on <b>1-30-82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (he) (we) (did) (did not) view the body after death.   |  |                         |  |  |  |   |  |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br><b>Laurence R. Gallager</b>  |  |                         |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |  | 22c. DATE SIGNED<br><b>2-1-82</b>   |  |  |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>LAURENCE R. GALLAGER, M.D.</b>   |  |                         |  |  |  | 22e. ADDRESS<br><b>ST. AGNES MEDICAL CENTER</b>   |  |  |   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  |                         | 23b. DATE<br><b>02-02-82</b>   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>NEW CATHEDRAL</b>  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE CITY MARYLAND</b>                    |  |  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.</b>  |  |                         |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 1 1982</b>  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>James J. [Signature]</b>                                       |  |  |   |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

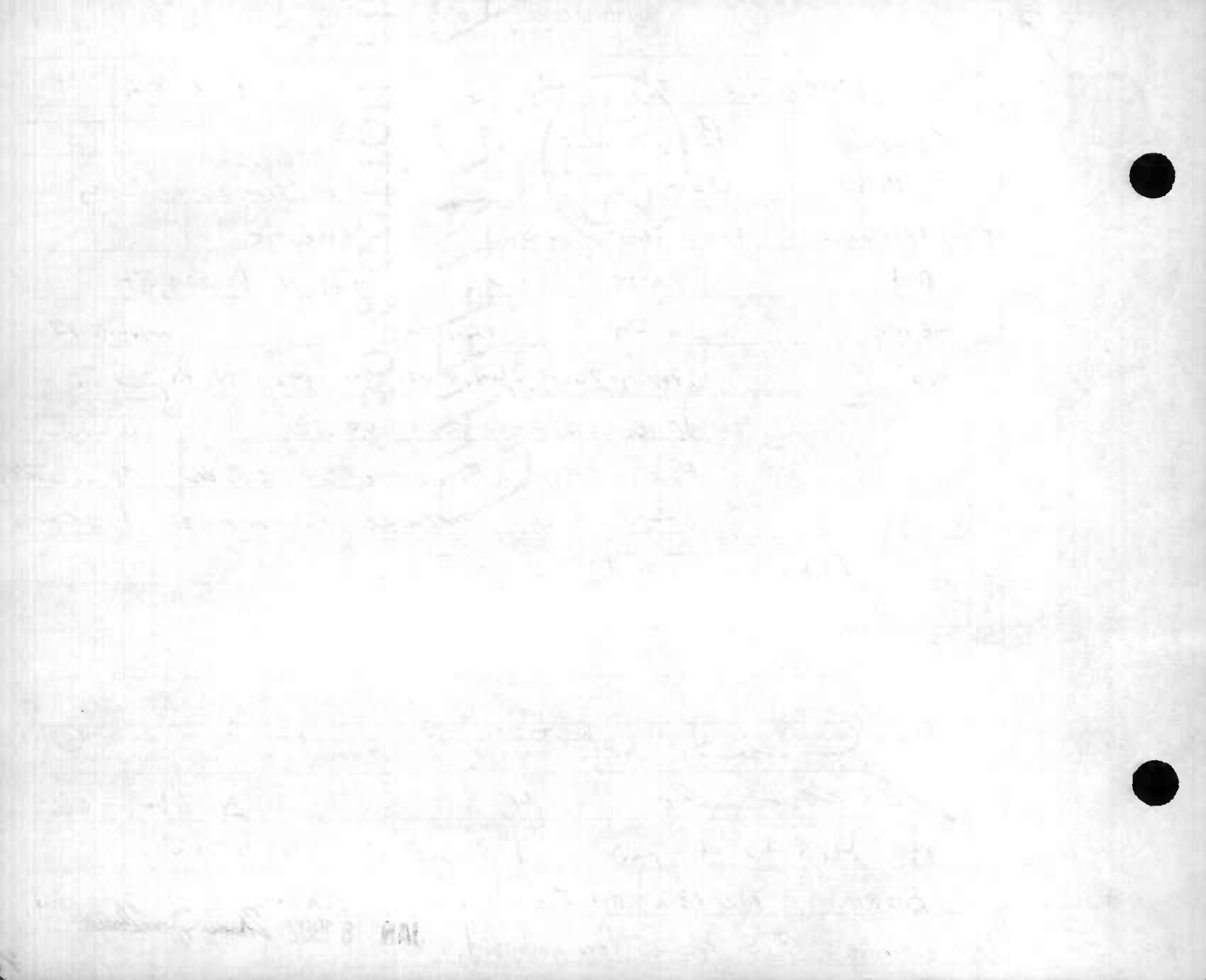
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

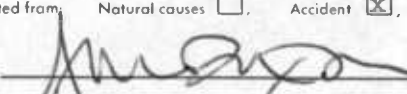
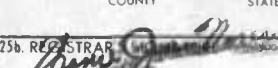
8 2 0 1 4 9 9

REG. NO.

|  |  |   |  |   |  |   |  |  |  |
|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>CHRISTINE C. SMITH</b>  |  |   | 2a. DATE OF DEATH MONTH <b>1</b> DAY <b>1</b> YEAR <b>82</b> |   |  | 2b. HOUR <b>M</b>   |  |  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>B</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>8</b> DAY <b>19</b> YEAR <b>28</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>53</b>  |  | 7. IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Provident Hosp.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Domestic</b>             |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>md.</b>   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>BALTO.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1721 N. Payson St.</b>   |  |
| 14. FATHER'S NAME<br>FIRST <b>HENRY</b> MIDDLE <b>SMITH</b> LAST <b>SMITH</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>ANITA</b> MIDDLE <b>WATKINS</b> LAST <b>WATKINS</b>  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>290-24-3061</b>  |  | 17. INFORMANT ADDRESS<br><b>Gladys Wilson 1721 N. Payson St</b>   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO RESPIRATORY ARREST</b><br><b>1991</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>METASTATIC CARCINOMA TO BRAIN</b> 4 months<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>CARCINOMA UNKNOWN PRIMARY SITE</b> 1 year<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10 min</b> |  |   |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)<br><b>Urinary Tract Infection</b>   |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Sept 9 1981</b> to <b>Jan 1 1982</b> , that (I) (we) lost<br>saw the deceased <b>live on</b> <b>Dec 31 1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>A. Miranda</b>  |  | DEGREE<br><b>MD</b>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  |   |  | 22c. DATE SIGNED<br><b>1-1-82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>A. MIRANDA, MD</b>   |  | 22e. ADDRESS<br><b>Provident Hospital</b>   |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>1/5/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Zion Cem.</b>  |  | 23d. LOCATION<br>CITY OR TOWN <b>BALTO.</b> COUNTY <b>MD.</b> STATE <b>MD.</b>                  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>HEROY HARRIS</b> F/S <b>4520 Pen Lucy Rd.</b> ADDRESS  |  |   |  | 25a. DATE RECEIVED BY FUNERAL DIRECTOR<br><b>JAN 8 1982</b>   |  |   |  |  |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 1 AND 2 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| FOR<br>1- STATE<br>REGISTRAR   |  |                         |  |   |  |   |  |  |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |   |  |  |  |  |  | MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                                 |  |  |  |  |  |  |  | REG. NO. 8 2 0 1 5 0 0 |  |  |  |  |  |  |  |  |  |
|--|--|-------------------------|--|---|--|---|--|--|--|---|--|--|--|---|--|--|--|--|--|---|--|---------------------------------|--|--|--|--|--|--|--|------------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>DONALD N. SMITH</b>   |  |                         |  |   |  |   |  |  |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input type="checkbox"/> MONTH DAY YEAR 19 <b>1</b> 1 1982 |  |  |  |   |  |  |  |  |  | 2b. HOUR <b>4:11</b> M <b>P</b>   |  |                                 |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |
| 3. SEX<br><b>male</b>  |  | 4. RACE<br><b>white</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>9 7 24</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>57 YRS.</b> |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.   |  | IF UNDER 24 HRS.  |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR <b>1 1 1982</b>                           |  |   |  |  |  |  |  |   |  | 2d. HOUR <b>4:11</b> M <b>P</b> |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Ohio</b>   |  |                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD                     |  |   |  |  |  |  |  |   |  |                                 |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  |                         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>49 E. Hughes St.</b> |  |   |  |  |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                        |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY                            |  |  |  |   |  |                                 |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |
| 13a. STATE<br><b>Md.</b>   |  |                         |  | 13b. COUNTY   |  |   |  | 13c. CITY OR TOWN<br><b>Balto.</b>   |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  | 13e. STREET ADDRESS<br><b>49 E. Hughes St. (vacant home)</b> |  |  |  |   |  |                                 |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |  |                         |  |   |  |   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |  |  |  |   |  |  |  |  |  |   |  |                                 |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>Unkn.</b>  |  |                         |  | 16b. SOCIAL SECURITY NO.  |  |   |  | 17. INFORMANT ADDRESS  |  |   |  |  |  |   |  |  |  |  |  |   |  |                                 |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hypothermia</b><br>9010<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b)<br>(c)<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF  |  |                         |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |   |  |  |  |  |  |   |  |                                 |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                         |  |   |  |   |  |  |  |   |  |  |  |   |  |  |  |  |  |   |  |                                 |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |  |  |   |  |  |  |   |  |  |  |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                                 |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>12/31/81</b>   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Exposure to cold</b>   |  |   |  |  |  |   |  |  |  |  |  |   |  |                                 |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>building</b>  |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>49 E. Hughes St. Baltimore Md.</b>   |  |   |  |  |  |   |  |  |  |  |  |   |  |                                 |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> inspection <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                         |  |   |  |   |  |  |  | TITLE (SPECIFY)<br>M.D. <b>Assistant</b> MEDICAL EXAMINER                                       |  |  |  |   |  |  |  |  |  | DATE SIGNED <b>1-2-82</b>   |  |                                 |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE<br>  |  |                         |  |   |  |   |  |  |  | EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>                                       |  |  |  |   |  |  |  |  |  | ADDRESS <b>111 Penn St.</b>   |  |                                 |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Removal</b>  |  |                         |  | 23b. DATE<br><b>1/13/82</b>   |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |   |  |  |  |  |  |   |  |                                 |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Anatomy Board Balto., Md.</b>   |  |                         |  |   |  |   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 2 2 1982</b>  |  |  |  | 25b. REGISTRAR<br> |  |  |  |  |  |   |  |                                 |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |



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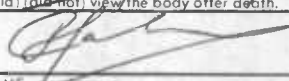

1992, 1993, 1994

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 8 2 0 1 5 0 1   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1 - FOR STATE REGISTRAR  |  |  |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Eileen Arlene Smith</b>   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>01 26 82</b>  |  | 2b. HOUR<br><b>3:15pm</b>  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>07 04 15</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Agnes Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>Maryland</b>  |  |  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Catonsville</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Albert E. Clark</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary A. Sullivan</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>213-03-0514</b>   |  | 17. INFORMANT ADDRESS<br><b>Robert C. Smith 269 Berrywood Drive 21146</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b><br><b>4850</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>14 DAYS</b>        |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>ARTERIO-SCLEROTIC CEREBROVASCULAR DISEASE WITH MULTIPLE INFARCTIONS</b>   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/12/82</b> to <b>1/26/82</b> , that (I) (we) lost<br>saw the deceased alive on <b>1/26/82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br>  |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>1/26/82</b>   |  |
| 22d. PHYSICIAN'S NAME (LAST OR PRINT)<br><b>Dr. Halma</b>  |  | 22e. ADDRESS<br><b>ST. AGNES HOSPITAL<br/>900 CATON AVENUE</b>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>1/29/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Hubbard Funeral Home, Inc.</b>  |  | 24b. ADDRESS<br><b>4107 Wilkens Ave.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 29 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br>        |  |

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growth rate

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 5 0 2

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |   |  |   |  |  |  |                                   |  |
|--|---|--|---|--|--|--|-----------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                  |   |  | 2a. DATE OF DEATH   |  |  | 2b. HOUR                                   |                                   |  |
| FREDERICK HANAWAY SMITH, SR.   |   |  | 1/11/82   |  |  | 10:45 AM                                   |                                   |  |
| 3. SEX   | 4. RACE   | 5. DATE OF BIRTH   | 6. AGE  |  |  | 7. IF UNDER 1 YEAR                         |                                   |  |
| Male   | White   | 4 MONTH 19 DAY 14 YEAR   | 67 YRS  |  |  | IF UNDER 24 HRS.                           |                                   |  |
| 8. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)                          | 9. CITIZEN OF WHAT COUNTRY?   | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |                                   |  |
| Maryland   | U.S.A.  |  | Balt. City MD.  |  |  |  |                                   |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| Baltimore  | BON SECOURS Hosp.   |  |   | Dental Lab Tec.  |  |  |                                   |  |
| 13a. STATE   | 13b. COUNTY   | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS  |  |  | 21229                             |  |
| Maryland   |   | Baltimore  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 203 Atholgate Lane Apt. D  |  |  |                                   |  |
| 14. FATHER'S NAME  |   |  | 15. MOTHER'S MAIDEN NAME  |  |  |  |                                   |  |
| FIRST MIDDLE LAST<br>Frederick L. Smith                              |   |  | FIRST MIDDLE LAST<br>Amy Little                                     |  |  |  |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) |   |  | 16b. SOCIAL SECURITY NO.  |  |  | 17. INFORMANT                              |                                   |  |
| YES WW II  |   |  | 216-03-3093   |  |  | Carolyn Smith 5827 Harpers Farm Road 21044 |                                   |  |

|  |  |   |  |
|--|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY: |  | APPROXIMATE INTERVAL<br>BETWEEN CAUSE AND DEATH |  |
| IMMEDIATE CAUSE (a)  |  | 4100 Cardio Pulmonary Arrest                    |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  | Acute myocardial infarction                     |  |
| (b)  |  | 4100  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  | Hypertension                                    |  |
| (c)  |  | Hypertension                                    |  |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11c

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | YES <input type="checkbox"/> NO <input type="checkbox"/>          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |   |  |
|   |  |  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |
|   |  |  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/11/82 to 1/11/82, that (I) (we) lost<br>saw the deceased alive on 1/11/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE  |  | DEGREE   |  |  |  | 22c. DATE SIGNED  |  |
| [Signature]   |  | MD   |  |  |  | 1/11/82   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |  |  |   |  |
| Francisco F. Martinez   |  | 1940 W. Belfer St Baltimore Md.  |  |  |  |   |  |

|  |  |           |  |                                    |  |  |  |
|--|--|-----------|--|------------------------------------|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) |  | 23b. DATE |  | 23c. NAME OF CEMETERY OR CREMATORY |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |  |
| Burial                                       |  | 1/13/82   |  | Meadowridge Mem. Park Elkridge     |  | Howard Co. Md.                             |  |
| 24. FUNERAL DIRECTOR<br>NAME                 |  |           |  | 25a. DATE REC'D. BY REGISTRAR      |  | 25b. SIGNATURE                             |  |
| Hubbard Funeral Home, Inc. 4107 Wilkens Ave. |  |           |  | 21229                              |  | JAN 13 1982 [Signature]                    |  |

instituted 1951-52 HRL

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |               |  |   |  |  |  |  |  | REG. NO. 8 2 0 1 5 0 3   |  |  |  |   |  |
|---|--|---------------|--|---|--|--|--|--|--|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) George A. Smith, Sr.  |  |               |  |   |  |  |  |  |  | 2a. DATE KNOWN OF DEATH<br>XX MONTH DAY YEAR 1 3 19 82                           |  | 2b. HOUR M 9:13P   |  |   |  |
| 3. SEX male   |  | 4. RACE black |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR 1 5 17   |  | 6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.              |  | 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.   |  | 7c. DATE PRONOUNCED DEAD 1 3 19 82   |  | 7d. HOUR 9:13P   |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland  |  |               |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.   |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD                                       |  |   |  |
| 10. CITY OR TOWN OF DEATH Baltimore   |  |               |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lutheran Hospital |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |
| 13a. STATE MD   |  |               |  | 13b. COUNTY   |  |  |  | 13c. CITY OR TOWN Baltimore  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS 2107 N. Ellamont St.              |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST Walter Smith   |  |               |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST Agnes Parker  |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes   |  |  |  | 16b. SOCIAL SECURITY NO. 216-07-1997   |  | 17. INFORMANT ADDRESS Peggy L. Rice 3105 Clifton Ave. |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4292 Arteriosclerotic cardiovascular disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |               |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                     |  |  |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |               |  |   |  |  |  |  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  |               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |               |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |  |               |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |               |  |   |  |  |  |  |  |  |  |  |  |   |  |
| ACTUAL SIGNATURE <i>Hormez R. Guard</i>   |  |               |  | TITLE (SPECIFY) Assistant   |  |  |  | DATE SIGNED 1/4/82   |  |  |  |  |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D.   |  |               |  | ADDRESS 111 Penn Street, Baltimore, MD 21201  |  |  |  |  |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial  |  |               |  | 23b. DATE 1/11/82   |  | 23c. NAME OF CEMETERY OR CREMATORY MD. VETERANS CEM. |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville MD                           |  |  |  |   |  |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/H, Inc. ADDRESS 1101 E. North Ave.   |  |               |  |   |  | 25a. DATE REC'D. BY REGISTRAR JAN 6 1982             |  | 25b. REGISTRAR'S SIGNATURE <i>James J. [Signature]</i>   |  |  |  |  |  |   |  |

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Wm. H. H. H.

Wm. H. H. H.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 5 0 4

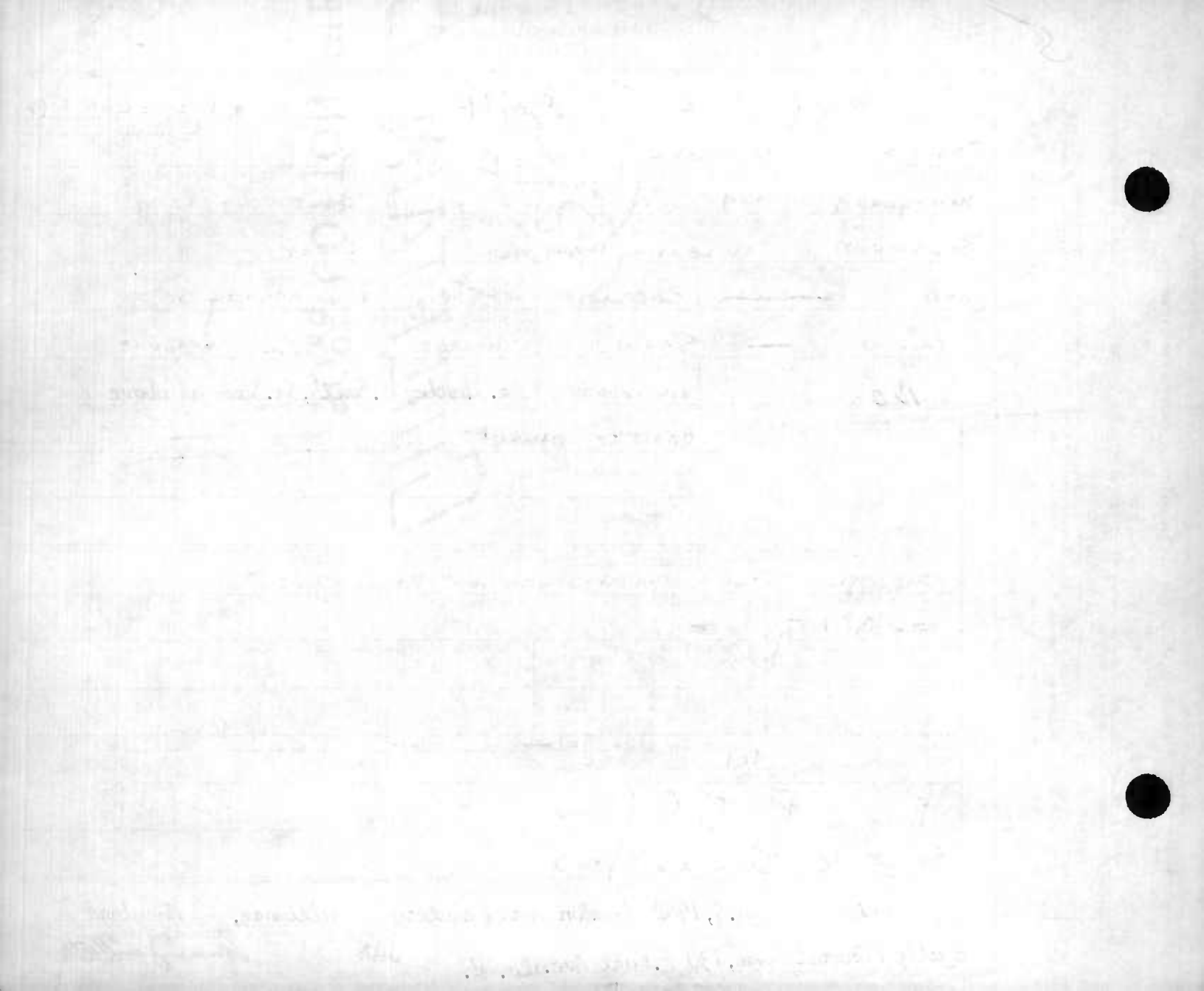
REG. NO.

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MARY MIDDLE E LAST SMITH  |  | 2a. DATE OF DEATH MONTH DAY YEAR 1 2 82   |  | 2b. HOUR 10:54 PM   |  |
| 3. SEX FEMALE   |  | 4. RACE CAUCASIAN   |  | 5. DATE OF BIRTH MONTH DAY YEAR 06 19 25  |  |
| 6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND   |  | 7b. CITIZEN OF WHAT COUNTRY? USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.   |  | 10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLERK  |  | 11. KIND OF BUSINESS OR INDUSTRY  |  |
| 12. CITY OR TOWN OF DEATH BALTIMORE   |  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSAL HOSPITAL |  | 14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY BALTIMORE 13c. CITY OR TOWN BALTIMORE |  |
| 15. FATHER'S NAME FIRST CAWLOW MIDDLE SNOW LAST   |  | 16. MOTHER'S MAIDEN NAME FIRST MARIE MIDDLE ELLA LAST MALONE  |  | 17. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO  |  | 18b. SOCIAL SECURITY NO. 219-18-6758  |  | 19. INFORMANT ADDRESS Mr. Stanley W. Smith, Sr. Same as above   |  |
| 20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4275 CARDIAC ARREST<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Hemolytic Anemia, Thrombocytopenia, Renal Failure  |  |   |  |   |  |
| 21a. DATE OF OPERATION 12/25/82   |  | 21b. CONDITION FOR WHICH OPERATION WAS PERFORMED Splenectomy  |  | 21c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 21d. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21e. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 12 P.M. 19 82  |  | 21f. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |
| 21g. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21h. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21i. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |
| 22. I certify that (I) (this hospital) attended the deceased from 12/25/82 to 12/25/82, that (I) (we) lost saw the deceased alive on 12/25/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |
| 23a. SIGNATURE (TYPE OR PRINT) David R. Balfanz   |  | DEGREE  |  | 23c. DATE SIGNED 1/2/82   |  |
| 23b. PHYSICIAN'S NAME (TYPE OR PRINT) David R. Balfanz  |  | 23d. ADDRESS  |  | 23e. DATE REC'D. BY REGISTRAR 5 1982  |  |
| 24. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial   |  | 24b. DATE Jan. 5, 1982  |  | 24c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery   |  |
| 24d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland   |  | 24e. DATE REC'D. BY REGISTRAR 5 1982  |  | 24f. REGISTRAR'S SIGNATURE  |  |
| 24g. FUNERAL DIRECTOR NAME McCully Funeral Home, 130 E. Fort Ave. Baltimore, Md.  |  | 24h. ADDRESS  |  | 24i. DATE REC'D. BY REGISTRAR 5 1982  |  |

MEDICAL CERTIFICATION

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 5 0 5

REG. NO.

|  |  |   |  |   |                                |   |   |  |  |
|--|--|---|--|---|--------------------------------|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>PAULINE NMI SMITH   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>01 23 82                      |   |                                | 2b. HOUR<br>1045 p.m.   |   |  |  |
| 3. SEX<br>F  |  | 4. RACE<br>B  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>04 29 03  |                                | 6. AGE (IN YEARS LAST BIRTHDAY)<br>78 YRS.  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>US  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE CITY  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNIVERSITY OF MD. HOSPITAL |  |   |                                | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                      |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>Maryland   |  |   | 13b. COUNTY  |   | 13c. CITY OR TOWN<br>Baltimore |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William Thomas   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Elizabeth McDonnell |   |                                | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES)<br>No |   |  |  |
| 16b. SOCIAL SECURITY NO.<br>215-14-9713  |  |   | 17. INFORMANT ADDRESS<br>Wardell Young 2401 Calverton Hght.          |   |                                |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) RESPIRATORY FAILURE<br>DUE TO, OR AS A CONSEQUENCE OF (b) BRONCHOSPASM<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PULMONARY NEOPLASM WITH POST OBSTRUCTIVE PNEUMONIA<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 WEEK<br>UNKNOWN DURATION<br><del>3 WEEKS</del> |  |   |  |   |                                |   |   | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br>ASTHMA |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                             |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                                |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |                                |   |   |  |  |
| 22b. SIGNATURE<br>Scott T Maurer MD  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |                                |   |   | 22c. DATE SIGNED<br>1/23/82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>SCOTT T MAURER MD.  |  |   |  | 22e. ADDRESS<br>UNIVERSITY OF MARYLAND HOSPITAL   |                                |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>1-28-82  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Auburn  |                                | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. Md.  |   | 24. FUNERAL DIRECTOR<br>NAME<br>CHAS. A. RICE FSPA 1300 Eutaw Pl.  |  |
| 25a. DATE REC'D. BY REGISTRAR<br>FEB 1 1982  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br>Rene J. [Signature]   |                                |   |   |  |  |

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |  |  |   |  |  |
|---|--|---|--|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   | 2a. DATE OF DEATH  |   |  | 2b. HOUR   |   |  |  |
| ROOSEVELT SMITH   |  |   | MONTH DAY YEAR<br>1 16 82  |   |  | M  |   |  |  |
| 1. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |   | IF UNDER 1 YEAR<br>MONTHS DAYS                                 |  |
| Male  |  | Black   |  | MONTH DAY YEAR<br>10 12 13  |  | 68 YRS   |   | IF UNDER 24 HRS<br>HOURS MIN.                                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |   |  |  |
| South Carolina  |  | USA   |  |   |  | Baltimore CITY MD.   |   |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |   | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| Balto.  |  | Provident Hospital  |  |   |  | civil Service  |   |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |   |  |  |   |  |  |
| 13a. STATE  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?   |   | 13e. STREET ADDRESS  |  |
| Md.   |  |   |  | Balto.  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 3800 WABASH AVE.   |  |
| 14. FATHER'S NAME   |  |   |  | 15. MOTHER'S MAIDEN NAME  |  |  |   |  |  |
| FIRST MIDDLE LAST<br>Sam Smith  |  |   |  | FIRST MIDDLE LAST<br>Emma Dixon   |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   |  | 17. INFORMANT ADDRESS  |   |  |  |
| No  |  |   |  | 132 01 4691   |  | Evelyn Smith 3800 Wasbash Ave.   |   |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Obstructive Pulmonary Disease</u><br>4960<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>years</u> |  |   |  |   |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>Arteriosclerotic Cardiovascular Disease</u>  |  |   |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |   |  |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |
|   |  |   |  |   |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Feb</u> , 19 <u>78</u> , to <u>JAN</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>Sept</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br><u>Sheldon Goldgeier</u>  |  |   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><u>1/18/82</u>                             |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Sheldon Goldgeier</u>   |  |   |  |   |  | 22e. ADDRESS<br><u>711 W. 40th St. 21211</u>   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Burial</u>  |  |   | 23b. DATE<br><u>1/21/82</u>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Crownsville Vet. cem.</u> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Crownsville, Md.</u> |  |  |
| 24. FUNERAL DIRECTOR<br><u>LEROY O. DYETT</u> 4600 LIBERTY HEIGHTS AVE.   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><u>JAN 19 1982</u>  |   |  |  |
|   |  |   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><u>James Van Natten</u>  |   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Game? 1113

V

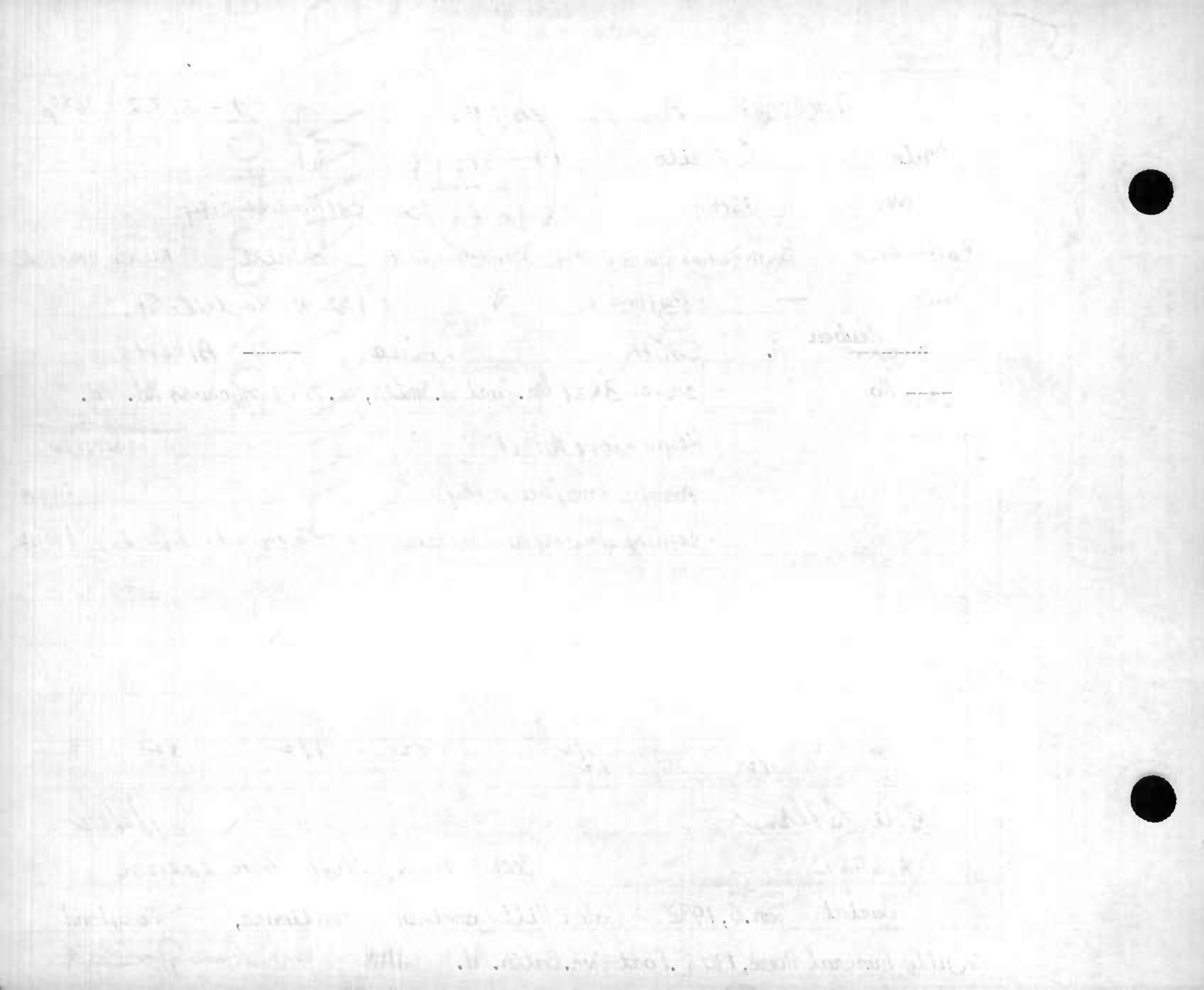
NO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the health department within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified before the body is released for burial or cremation.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |   |   |  |  |   |   |  |
|--|--|---|---|---|--|--|---|---|--|
| 1. FOR STATE REGISTRAR   |  |   |   |   | REG. NO.   |  |   |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>THEODORE A. SMITH</b>  |  |   |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>1-2-82</b>                              |  |   | 2b. HOUR<br><b>1030 P.M.</b>  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>10-31-00</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b>   |   | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore city</b> MD.  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>South Baltimore General Hosp. 3001 S. Hanover St</b> |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Machinist</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>ALLIED CHEMICAL</b>   |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>---</b>   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 13e. STREET ADDRESS<br><b>132 W. Randall St.</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Reuben A. Smith</b>  |  |   |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Louise --- Alberts</b>        |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>ONR No</b>   |  |   |   | 16b. SOCIAL SECURITY NO.<br><b>216-05-3821</b>  |  | 17. INFORMANT ADDRESS<br><b>Mr. Earl A. Smith, Jr. 114 Longcross Rd. Md.</b>   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b><br><b>4100</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Arterio encephalopathy</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Cardiopulmonary resuscitation 20 to acute myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Second</b><br><b>1 week</b><br><b>1 week</b> |  |   |   |   |  |  |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.  |  |   |   |   |  |  |   |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/2</b> , 19 <b>82</b> , to <b>1/2</b> , 19 <b>82</b> , that (I) (we) lost<br>saw the deceased alive on <b>1/2</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |   |   |   |  |  |   |   |  |
| 22b. SIGNATURE<br><b>D.A. Stern</b>  |  |   | DEGREE  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>1/4/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>D.A. STERN</b>   |  |   |   |   | 22e. ADDRESS<br><b>3001 S. Hanover Street Balto, Md 21230</b>                  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |   | 23b. DATE<br><b>Jan. 6, 1982</b>                                    |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b>               |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b> |   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>McGully Funeral Home, 130 E. Fort Ave. Balto. Md.</b>  |  |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 5 1982</b>                             |  | 25b. REGISTRAR'S SIGNATURE<br><b>Anna J. [Signature]</b>              |   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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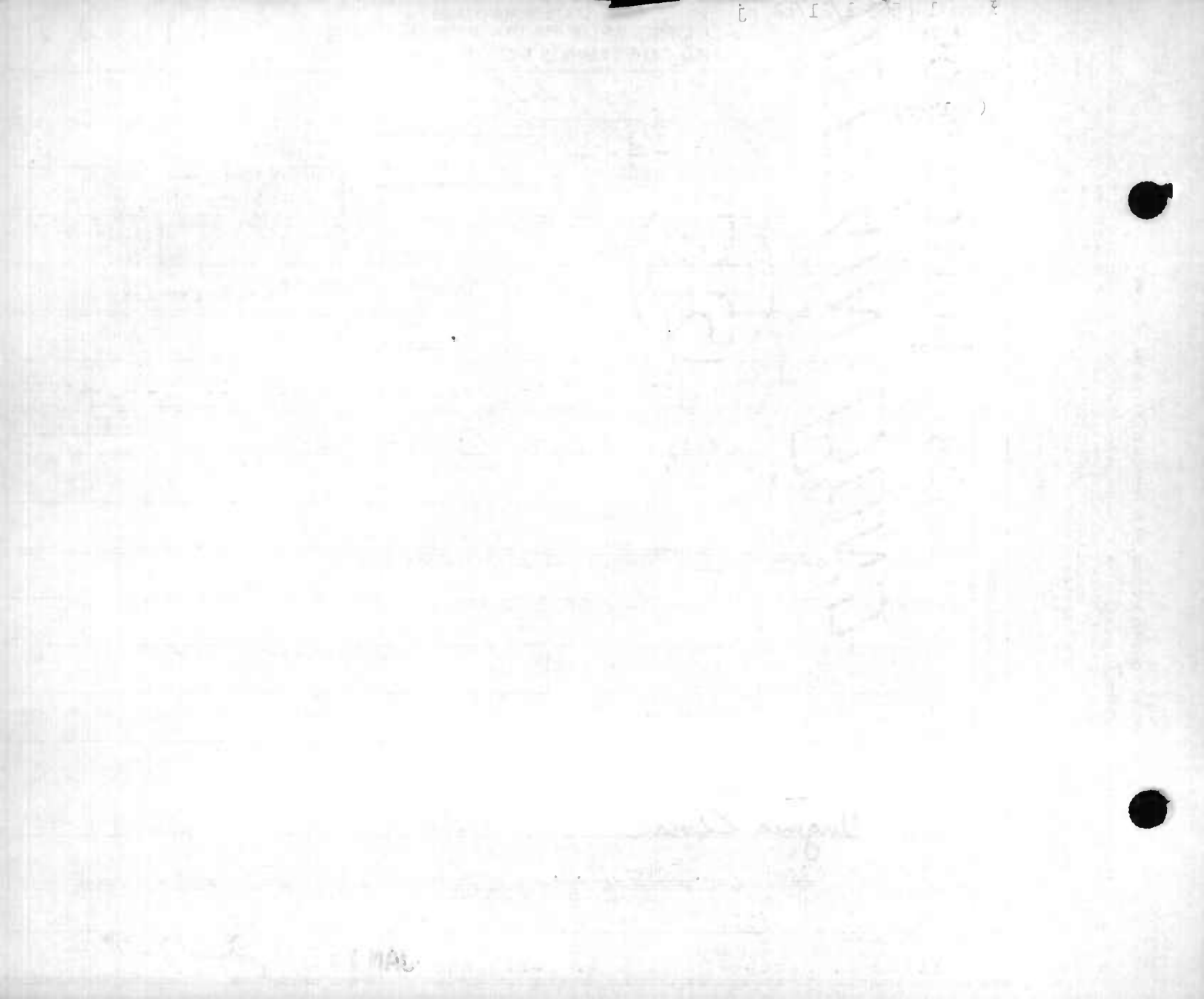
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|---|------------------|--|--|
| 1. FOR STATE REGISTRAR  |                  | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Violet R Smith  |                  | 2a. DATE OF DEATH MONTH DAY YEAR<br>01 02 82<br>2b. HOUR<br>11:02 PM   |  |
| 3 SEX<br>Female   | 4. RACE<br>White | 5. DATE OF BIRTH MONTH DAY YEAR<br>11 09 1899  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>82 YRS.  |                  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |                  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |                  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Belair Convalescium |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Receptionist  |                  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Funeral Home  |  |
| 13a. STATE<br>Maryland  |                  | 13b. COUNTY<br>Baltimore   |  |
| 13c. CITY OR TOWN<br>Overlea  |                  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                  |  |
| 13e. STREET ADDRESS<br>7401 Belair Road 21236   |                  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Wirsing  |                  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Unknown  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No  |                  | 16b. SOCIAL SECURITY NO.<br>212-16-0477  |  |
| 17. INFORMANT ADDRESS<br>Gerald V. Caldwell 7701 Belair Road  |                  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 439.2<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Atherosclerotic Cardiovascular Disease<br>yes.  |                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |                  |  |  |
| 19a. DATE OF OPERATION<br>X   |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |                  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK   |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |                  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from JUNE 19 72, to 01-02 19 82, that (I) (we) lost saw the deceased alive on 01-02 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                  |  |  |
| 22b. SIGNATURE<br>John C. Hyle  |                  | 22c. DATE SIGNED<br>1-4-82   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>John C. Hyle, M.D.   |                  | 22e. ADDRESS<br>7527 Belair Road 21236   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |                  | 23b. DATE<br>1/6/82  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood Cemetery   |                  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Parkville Baltimore Md.   |  |
| 24. FUNERAL DIRECTOR NAME<br>Lassahn Funeral Home   |                  | 24b. ADDRESS<br>7401 Belair Road   |  |

RECORDED BY REGISTRAR  
JAN 7 1982



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |               |  |   |  |   |  |  |                            | REG. NO. 01509   |  |
|---|--|---------------|--|---|--|---|--|--|----------------------------|--|--|
| 1. FOR item 5 and 6 G563 1/21/82 gJ<br>1- STATE REGISTRAR   |  |               |  |   |  |   |  |  |                            | 2. DATE KNOWN OF DEATH   |  |
| 1. DECEASED NAME (TYPE OR PRINT) (Walker) Walter F. Smith   |  |               |  |   |  |   |  |  |                            | 2. DATE KNOWN OF DEATH MATED XX 1 16 19 82                                       |  |
| 3. SEX Male   |  | 4. RACE Black |  | 5. DATE OF BIRTH MONTH DAY YEAR 2 17 84   |  | 6. AGE (IN YEARS) LAST BIRTHDAY 77 TRS                      |  | 7. IF UNDER 1 YR. MONTHS DAYS  |                            | 7. IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S. C.   |  |               |  | 7b. CITIZEN OF WHAT COUNTRY? USA  |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.                         |  |
| 10. CITY OR TOWN OF DEATH Baltimore   |  |               |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2902 Puget Street |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |                            | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE Md   |  |               |  | 13b. COUNTY   |  | 13c. CITY OR TOWN Baltimore                                 |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                            | 13e. STREET ADDRESS 2402 Puget Street  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST Joseph Smith  |  |               |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Wright |  |  |                            |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No   |  |               |  | 16b. SOCIAL SECURITY NO. 218-01-7176  |  | 17. INFORMANT ADDRESS Corine E. Stewart 1119 Race Street    |  |  |                            |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u><br>4292<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF   |  |               |  |   |  |   |  |  |                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                     |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |               |  |   |  |   |  |  |                            |  |  |
| 19a. DATE OF OPERATION  |  |               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |  |                            | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |               |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |                            |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |  |               |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |                            |  |  |
| 22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |               |  |   |  |   |  |  |                            |  |  |
| ACTUAL SIGNATURE Virginia L. Dolan  |  |               |  |   |  | TITLE (SPECIFY) M.D. Assistant                              |  |  | DATE SIGNED 1-17-82        |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.   |  |               |  |   |  | ADDRESS 111 Penn Street                                     |  |  |                            |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial  |  |               |  | 23b. DATE 1/22/82   |  | 23c. NAME OF CEMETERY OR CREMATORY Mt Auburn Cemetery       |  |  |                            | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD                             |  |
| 24. FUNERAL DIRECTOR NAME William C. March F/H 1101 E. North Ave  |  |               |  |   |  | 25a. DATE REC'D. BY REGISTRAR JAN 19 1982                   |  |  | 25b. REGISTRAR'S SIGNATURE |  |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER. GIVE PAGE 5 TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHHOLDING AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |                  |   |  |   |  |  |   |
|--|------------------|---|--|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Welton V. Smith   |                  |   | 2b. DATE KNOWN OF DEATH<br>XX MONTH DAY YEAR<br>1 6 19 82        |   |  | 2a. HOUR<br>3:48 A.M.  |   |
| 3. SEX<br>Male   | 4. RACE<br>Black | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>6 9 '14   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>67 YRS.                    | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | IF UNDER 24 HRS.   | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>1 6 19 82      |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>NO. WICH VA.  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.  |   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University Hospital - DOA |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>LABORER |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>CONSTRUCTION                                   |
| 13a. STATE<br>MD.  |                  | 13b. COUNTY<br>—  | 13c. CITY OR TOWN<br>BALTIMORE                                   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   | 13e. STREET ADDRESS<br>1631 LOEMAN ST.                                   |  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William ——— Smith  |                  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>LAURA ——— SMITH |   |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>YES   |                  | (IF YES, GIVE WAR OR DATES)<br>11/20/42 - 7/10/45   |  | 16b. SOCIAL SECURITY NO.<br>220-03-3327   |  | 17. INFORMANT<br>ADDRESS<br>Sara J. Smith 1631 LOEMAN ST     |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease<br>4292<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) ———<br>(c) ———<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF   |                  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |                  |   |  |   |  |  |   |
| 19a. DATE OF OPERATION   |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |                  |   |  |   |  |  |   |
| ACTUAL SIGNATURE<br>Virginia L. Dolan  |                  | TITLE (SPECIFY)<br>M.D. Assistant   |  |   | MEDICAL EXAMINER<br>DATE SIGNED 1-6-82                                   |  |   |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |                  | Virginia L. Dolan, M.D.   |  |   | ADDRESS<br>111 Penn Street   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |                  | 23b. DATE<br>1/11/82  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>CROWNSVILLE, V.A.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>CROWNSVILLE MD |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>JAMES A. MORTON F.H.   |                  |   |  | ADDRESS<br>1701 LAURENST.   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 12 1982                 |   |
|  |                  |   |  | 25b. REGISTRAR<br>James J. Smith  |  |  |   |

1501



JAN 18 1935



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 8 2 0 1 5 1 1   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  | CERTIFICATE OF DEATH  |  |  |  |
| I. DECEASED NAME<br>(TYPE OR PRINT)  |  |   |  | 2a. DATE OF DEATH   |  |  |  |
| FIRST MIDDLE LAST  |  |   |  | MONTH DAY YEAR  |  |  |  |
| Chester C. Snively   |  |   |  | 1 10 82   |  |  |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                |  |
| male   |  | white   |  | MONTH DAY YEAR<br>11 7 12   |  | 69 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |  |
| Maryland   |  | USA   |  |   |  | Baltimore City MD  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| Baltimore  |  | 3301 Woodring Avenue  |  | clerk   |  | Behbel.Steel Co  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  | 13d. INSIDE CITY LIMITS?  |  |  |  |
| 13a. STATE 13b. COUNTY 13c. CITY OR TOWN   |  |   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| Maryland Baltimore   |  |   |  | 13e. STREET ADDRESS   |  |  |  |
|  |  |   |  | 3301 Woodring Avenue  |  |  |  |
| 14. FATHER'S NAME  |  |   |  | 15. MOTHER'S MAIDEN NAME  |  |  |  |
| FIRST MIDDLE LAST  |  |   |  | FIRST MIDDLE LAST   |  |  |  |
| Cheselden Snively  |  |   |  | unknown   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)   |  |   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS  |  |
| no   |  |   |  | 213 07 3421   |  | Elizabeth Snively 3301 Woodring Avenue                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>TERMINAL CARCINOMA LUNG</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>PNEUMONIA</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>A SCVD.</u>                                       |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7/1/82</u> to <u>1/10/82</u> , that (I) (we) last saw the deceased alive on <u>12/15/81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |  |   |  |   |  |  |  |
| 22b. SIGNATURE   |  |   |  | DEGREE  |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 1/14/82  |  |
| 22e. ADDRESS   |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                     |  |
| Burial   |  | 1/13/82   |  | Parkwood Cemetery   |  | Baltimore Maryland   |  |
| 24. FUNERAL DIRECTOR<br>NAME   |  |   |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE                                     |  |
| Walter Dabrowski 1005 Dundalk Avenue   |  |   |  | JAN 20 1982   |  | Charles Jan Nether   |  |



RECEIVED  
JAN 20 1953  
U.S. AIR FORCE

1005 Rutherford Avenue  
 Berkeley, California 94701  
 Mr. J. Edgar Hoover  
 Federal Bureau of Investigation  
 Washington, D.C. 20535

J. Edgar Hoover  
 Director  
 Federal Bureau of Investigation  
 Washington, D.C. 20535

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO. 8 2 0 1 5 1 2  |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  |   |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>ELDRIDGE M. SNYDER</b>   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>01-26-82</b>   |  | 2b. HOUR<br><b>7:05pm</b>   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>7 12 1901</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.<br><b>80 YRS.</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>West Virginia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD.</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Church Hospital Corporation</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Steel Worker</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Beth. Steel</b>   |  |
| 13a. STATE<br><b>Maryland</b>  |  |  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Edgemere</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Francis Snyder</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Mary Bowers</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>213-07-9995</b>   |  | 17. INFORMANT ADDRESS<br><b>Eunice R. Snyder 3002 Wells Avenue Balto., MD. 21219</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO RESPIRATORY FAILURE</b><br><b>1533</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>METASTATIC CARCINOMA OF SIGMOID COLON</b><br>(c) <b>DUE TO, OR AS A CONSEQUENCE OF</b> |  |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>METASTATIC CARCINOMA OF LUNGS, DEHYDRATION</b>  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 19c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (SEE EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |  | 21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21c. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (1) this hospital attended the deceased from <b>01-14-82</b> to <b>01-26-82</b> that (1) we last saw the deceased alive on <b>01-26-82</b> and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (If not, did not view the body after death.)   |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>K George Thomas</b>   |  |  |  | 22c. DEGREE<br><b>CHURCH HOSPITAL CORPORATION</b>   |  | 22d. DATE SIGNED<br><b>1/26/82</b>  |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. K. GEORGE THOMAS M.D.</b>  |  |  |  | 22f. ADDRESS<br><b>100 N. BROADWAY BALTIMORE, MARYLAND 21231</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>1/30/1982</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Meadowridge</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>- Dorsey Maryland</b>   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Duda-Ruck, Inc.</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 29 1982</b>   |  |   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Thom Jan 29 1982</b>  |  |  |  |   |  |   |  |
| 26. ADDRESS<br><b>7922 Wise Avenue Dundalk, MD. 21222</b>  |  |  |  |   |  |   |  |

11



IN SENATE

January 1, 1901

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

DHMH-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 5 1 3

REG. NO.

|   |   |  |                                |  |  |   |  |
|---|---|--|--------------------------------|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) <i>Philip</i>  |   | MIDDLE   |                                | 2a. DATE OF DEATH MONTH DAY YEAR 1 15 82   |  | 2b. HOUR 9:50 A   |  |
| 3. SEX <i>Male</i>  | 4. RACE <i>CAUCASIAN</i>  | 5. BIRTH APRIL 09 1895   |                                | 6. AGE (IN YEARS LAST BIRTHDAY) 86   |  | 7. IF UNDER 1 YEAR MONTHS DAYS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>N.Y.</i>   | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Balt. Co.</i>  |  | 10. MD  |  |
| 10. CITY OR TOWN OF DEATH <i>Balt.</i>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Levindale</i> |  |                                | 12a. USUAL OCCUPATION (TYPE OR NATURE OF WORK OF WORKING LIFE) <i>FOREMAN</i>  |  | 12b. KIND OF BUSINESS OR INDUSTRY <i>LADIES SWEATERS</i>  |  |
| 13a. STATE <i>MD.</i>   |   | 13b. COUNTY <i>BALTO.</i>  | 13c. CITY OR TOWN <i>Balt.</i> | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS <i>3715 Park Heights Ave, S.W.</i>  |  |
| 14. FATHER'S NAME FIRST <i>SIMON</i> MIDDLE LAST <i>SOFFER</i>  |   | 15. MOTHER'S MAIDEN NAME FIRST <i>FANNY</i> MIDDLE LAST <i>GURSKY</i>  |                                |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>   |   | 16b. SOCIAL SECURITY # <i>550-12-7854</i>  |                                | 17. INFORMANT <i>MRS. ADELE KRAVITZ</i>  |  |   |  |
|   |   |  |                                | 18. EAST-WEST HIGHWAY  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |   |  |                                |  |  |   |  |
| PART 1. DEATH WAS CAUSED BY:  |   |  |                                |  |  |   |  |
| IMMEDIATE CAUSE (a) <i>Fluid + electrolyte imbalance</i>  |   |  |                                |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chronic renal failure</i>   |   |  |                                |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <i>2 days yrs.</i>   |   |  |                                |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |   |  |                                |  |  |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |                                | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                                | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) this hospital attended the deceased from <i>11/13</i> 19 <i>82</i> to <i>9/23</i> 19 <i>81</i> , that (I) (we) last saw the deceased alive on <i>11/13</i> 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death. |   |  |                                |  |  |   |  |
| 22b. SIGNATURE <i>Stevenson</i>   |   | DEGREE <i>MD</i>   |                                | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED <i>1/15/82</i>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>S. LEVENSON, M.D.</i>  |   | 22e. ADDRESS <i>LEVINDALE - BALTO., MD</i>   |                                |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>   |   | 23b. DATE <i>JAN. 18, 1982</i>   |                                | 23c. NAME OF CEMETERY OR CREMATORY <i>CHIZUK AMUNO</i>   |  | 23d. LOCATION CITY OR TOWN COUNTY MARYLAND  |  |
| 24. FUNERAL DIRECTOR <i>SOL LEVINSON &amp; BROS., INC.</i>  |   |  |                                | 25a. DATE REC'D. BY REGISTRAR <i>JAN 20 1982</i>   |  |   |  |
| NAME <i>6010 REISTERSTOWN RD. BALTO., MD 21215</i>  |   |  |                                | 25b. REGISTRAR'S SIGNATURE <i>Francis J. Katten</i>  |  |   |  |

BP

JAN 80 1985



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8 2 0 1 5 1 4   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  |   |  | REG. NO.  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ANNA SOKOLOWSKI</b>   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>JANUARY 18, 1982</b>  |  |   |  |
| 3. SEX <b>Female</b>   |  |   |  | 2b. HOUR <b>2:50a</b>   |  |   |  |
| 4. RACE <b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>January 19, 1901</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD.</b>   |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Church Hospital Corporation</b>  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Cigar Stripper</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Tobacco</b>  |  |
| 13a. STATE <b>Maryland</b>   |  | 13b. COUNTY <b>---</b>  |  | 13c. CITY OR TOWN <b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>Andrew --- Nietubicz</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Josephine --- Skopinski</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>  |  | 16b. SOCIAL SECURITY NO. <b>214-26-8510</b>   |  |
| 17. INFORMANT <b>Philadelphia, Pa. 19128</b>   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>VENTRICULAR FIBRILLATION</b><br>4292<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b><br>CONGESTIVE HEART FAILURE<br>(c) <b>DIABETES MELLITUS AND GANGRENE</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>DIABETES MELLITUS AND GANGRENE</b>  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>NOVEMBER 12, 1981</b> to <b>JANUARY 18, 1982</b> , that (I) (we) last saw the deceased alive on <b>JANUARY 18, 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>V. SIVAN M.D.</b>   |  | DEGREE <b>M.D.</b>  |  | 22c. DATE SIGNED<br><b>1/18/82</b>  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>V. SIVAN</b>   |  |
| 22e. ADDRESS<br><b>CHURCH HOSPITAL CORPORATION</b>   |  | 22f. ADDRESS<br><b>100 N. BROADWAY 21231 BALTIMORE Md.</b>  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>   |  | 23b. DATE <b>1/21/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>St. Stanislaus Cem.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>Baltimore City, Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>George A. Weber &amp; Sons Inc.</b>  |  | ADDRESS <b>705 S. Ann St.</b>   |  | 25a. DATE REC'D. BY REGISTRAR <b>JAN 20 1982</b>  |  | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>   |  |



[illegible]

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

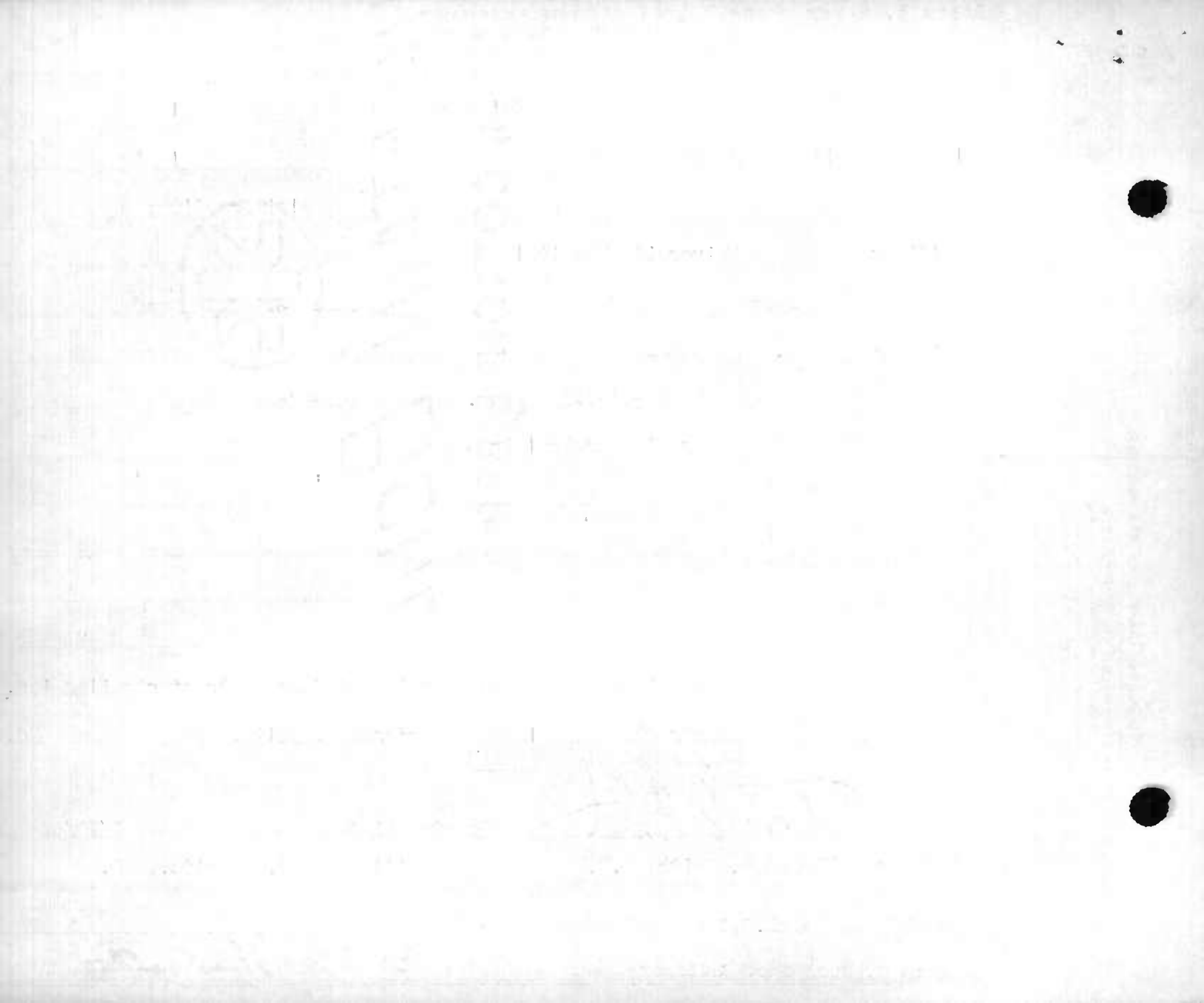
REG. NO.

2 01515

|  |   |  |                                 |   |                  |   |  |
|--|---|--|---------------------------------|---|------------------|---|--|
| 1. FOR STATE REGISTRAR   |   | 2a. DATE KNOWN OF DEATH  |                                 | MONTH DAY YEAR  |                  | 2b. HOUR  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |   | FIRST MIDDLE LAST  |                                 | MONTH DAY YEAR  |                  | 2b. HOUR  |  |
| Frank Joseph Solesky   |   |  |                                 | 1 30 1982   |                  | M   |  |
| 3. SEX   | 4. RACE   | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YR.  | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD  | 2d. HOUR                                     |
| Male   | White   | 6/4/56   | 25 YRS.                         |   |                  | 1 30 1982   | 4:49 a.m.                                    |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH  |                  |   |  |
| Md.  | USA   |  |                                 | Baltimore City, MD  |                  |   |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |                                 | 12b. KIND OF BUSINESS OR INDUSTRY   |                  |   |  |
| Baltimore  | University Hospital   | Salesman   |                                 |   |                  |   |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |   | 13d. INSIDE CITY LIMITS?   |                                 | 13e. STREET ADDRESS   |                  |   |  |
| 13a. STATE 13b. CITY OR TOWN   |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                 | 8125 Barksdale Road   |                  |   |  |
| Md. Baltimore  |   |  |                                 |   |                  |   |  |
| 14. FATHER'S NAME  |   | 15. MOTHER'S MAIDEN NAME   |                                 |   |                  |   |  |
| FIRST MIDDLE LAST  |   | FIRST MIDDLE LAST  |                                 |   |                  |   |  |
| Kenneth O. Solesky   |   | Jacqueline G. Curreri  |                                 |   |                  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |   | 16b. SOCIAL SECURITY NO.   |                                 | 17. INFORMANT ADDRESS   |                  |   |  |
| no   |   | 218-70-7730  |                                 | Mr. Kenneth O. Solesky Same   |                  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |   |  |                                 |   |                  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I DEATH WAS CAUSED BY:  |   |  |                                 |   |                  |   |  |
| IMMEDIATE CAUSE (a) <u>Cranio cerebral trauma</u>  |   |  |                                 |   |                  |   |  |
| 8121   |   |  |                                 |   |                  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |   |  |                                 |   |                  |   |  |
| (b) _____  |   |  |                                 |   |                  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |   |  |                                 |   |                  |   |  |
| (c) _____  |   |  |                                 |   |                  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |   |  |                                 |   |                  |   |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |                                 |   |                  | 20. AUTOPSY?  |  |
|  |   |  |                                 |   |                  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |                                 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |                  |   |  |
|  |   | 4 1 30 1982  |                                 | passenger in auto/parked tractor trailer imp.                                 |                  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |                                 | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                |                  |   |  |
|  |   | street   |                                 | 1-695 & Harford Rd. Balto. Md.  |                  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from <input type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |   |  |                                 |   |                  |   |  |
| ACTUAL SIGNATURE   |   | TITLE (SPECIFY)  |                                 | DATE SIGNED   |                  |   |  |
|  |   | M.D. Deputy Chief  |                                 | 1/30/82   |                  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |   | ADDRESS  |                                 |   |                  |   |  |
| Thomas D. Smith, M.D.  |   | 111 Penn St. Balto., MD.   |                                 |   |                  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |   | 23b. DATE  |                                 | 23c. NAME OF CEMETERY OR CREMATORY  |                  | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |  |
| Burial   |   | Feb. 2, 1982   |                                 | Moreland Mem. Park  |                  | Baltimore Md.   |  |
| 24. FUNERAL DIRECTOR NAME  |   | ADDRESS  |                                 | 25a. DATE REC'D. BY REGISTRAR   |                  | 25b. REGISTRAR'S SIGNATURE  |  |
| Leonard J. Ruck Inc. Baltimore, Maryland   |   |  |                                 | FEB 1 1982  |                  |   |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 5 1 6

|   |   |  |                                 |  |  |
|---|---|--|---------------------------------|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |   | 2a. DATE OF DEATH  |                                 | 2b. HOUR   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |   | MONTH DAY YEAR   |                                 | MONTH DAY YEAR   |  |
| Catherine Ford Sommers  |   | 1/17/82  |                                 | 6:42 P.M.  |  |
| 3. SEX  | 4. RACE   | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY) |  |  |
| Female  | White   | MONTH DAY YEAR   | 88 YRS.                         |  |  |
| 11. CITY OR TOWN OF DEATH   | 12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | 13. INSIDE CITY LIMITS?  |                                 | 13b. STREET ADDRESS                                      |  |
| Baltimore   | Baltimore City Hospital                                 | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                                 | 3507 Bank Street   |  |
| 14. FATHER'S NAME   | 15. MOTHER'S MAIDEN NAME                                | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?   |                                 |  |  |
| Daniel Ford   | Catherine Kuehn   | 16b. SOCIAL SECURITY NO.   |                                 |  |  |
|   |   | 213-74-4577  |                                 |  |  |
|   |   | 17. INFORMANT  |                                 |  |  |
|   |   | Catherine S. Wacker  |                                 |  |  |
|   |   | ADDRESS 3507 Bank Street Balto., MD. 21224   |                                 |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |   |  |                                 |  |  |
| PART 1. DEATH WAS CAUSED BY:  |   |  |                                 |  |  |
| IMMEDIATE CAUSE (a) <u>CARDIO - PULMONARY ARREST</u>  |   |  |                                 |  |  |
| 4100 DUE TO, OR AS A CONSEQUENCE OF   |   |  |                                 |  |  |
| (b) <u>TRANSMURAL MI</u>  |   |  |                                 |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |   |  |                                 |  |  |
| (c) _____   |   |  |                                 |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)               |   |  |                                 |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                 | 20a. AUTOPSY?  |  |
|   |   |  |                                 | YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>   |   | 21b. TIME OF INJURY  |                                 | 21c. HOW INJURY OCCURRED                                 |  |
| OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |   | HOUR A.M. MONTH DAY YEAR   |                                 | (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |  |
| (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | P.M. 19  |                                 |  |  |
| 21d. INJURY OCCURRED  |   | 21e. PLACE OF INJURY   |                                 | 21f. LOCATION  |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>   |   | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |                                 | STREET CITY OR TOWN COUNTY STATE                         |  |
| AT WORK AT WORK   |   |  |                                 |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost                          |   |  |                                 |  |  |
| saw the deceased alive on <u>1/17/82</u> , 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated |   |  |                                 |  |  |
| above. (b) (we) (did) (did not) view the body after death.  |   |  |                                 |  |  |
| 22b. SIGNATURE  |   | DEGREE   |                                 | 22c. DATE SIGNED   |  |
| <u>D. J. Smith</u>  |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                 | 1/17/82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |   | 22e. ADDRESS   |                                 |  |  |
|   |   |  |                                 |  |  |
| 23a. BURIAL, CREMATION, REMOVAL   |   | 23b. DATE  |                                 | 23c. NAME OF CEMETERY OR CREMATORY                       |  |
| (SPECIFY)   |   | 1/20/1982  |                                 | Oak Lawn   |  |
| Burial  |   |  |                                 |  |  |
| 24. FUNERAL DIRECTOR  |   | 25a. DATE REC'D. BY REGISTRAR  |                                 | 25b. REGISTRAR   |  |
| NAME  |   | ADDRESS  |                                 | SIGNATURE  |  |
| Suda-Ruck   |   | 7922 Wise Ave  |                                 | JAN 19 1982  |  |
|   |   |  |                                 |  |  |

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

15. [Illegible]

16. [Illegible]

17. [Illegible]

18. [Illegible]

19. [Illegible]

20. [Illegible]

21. [Illegible]

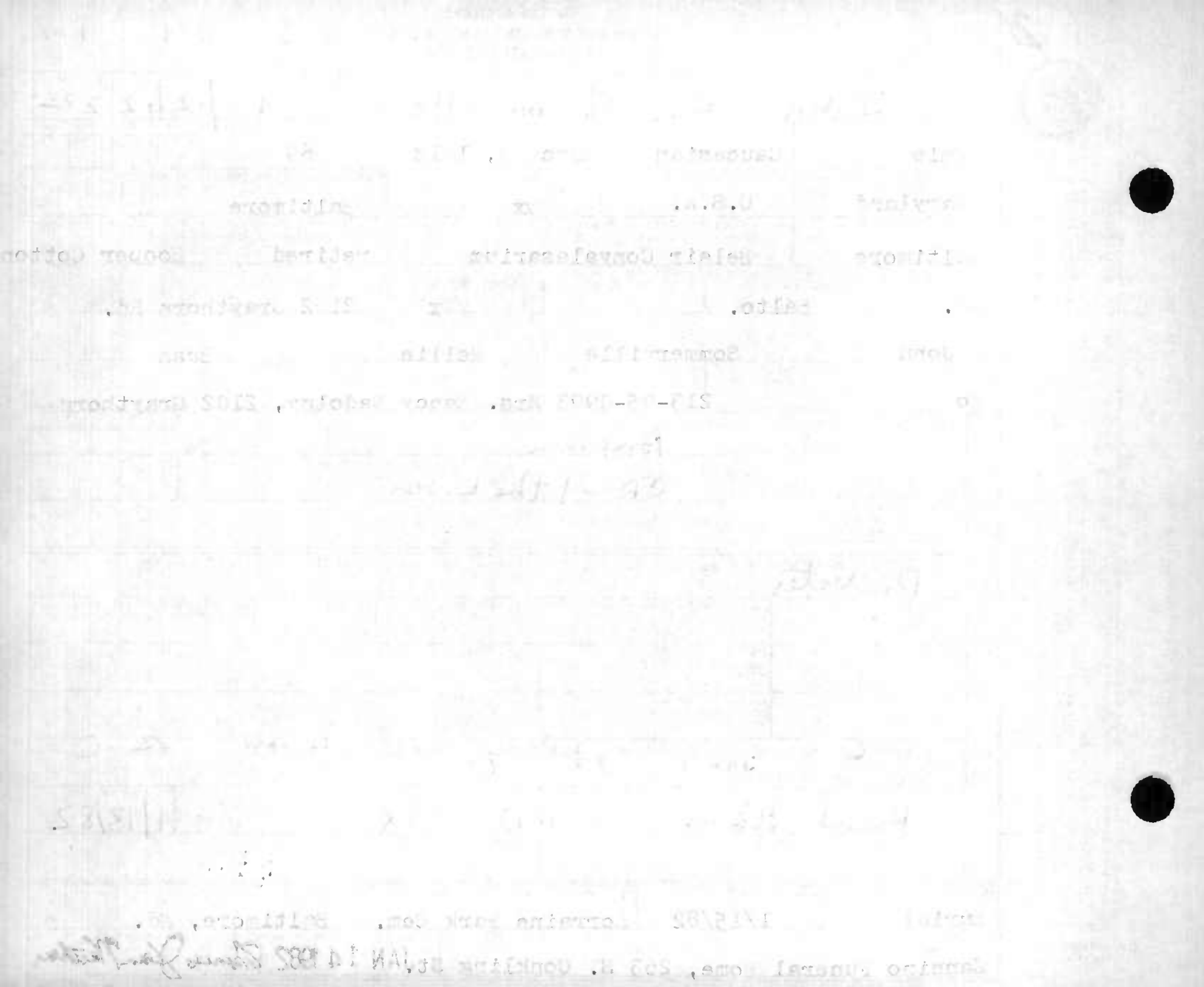
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 5 1 7

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>John L. Sommerville</b>   |  |   | 2a. DATE OF DEATH<br>MONTH <b>1</b> DAY <b>12</b> YEAR <b>82</b>                                      |  | 2b. HOUR<br><b>2:20</b> M  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>Caucasian</b>  | 5. DATE OF BIRTH<br>MONTH <b>March</b> DAY <b>3</b> YEAR <b>1912</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS.                              | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>         |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore</b> City MD.              |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Belair Convalesarium</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>retired</b>                    |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Hooper Cotton</b>  |
| 13a. STATE<br><b>Md.</b>   |  |   | 13b. COUNTY<br><b>Balto.</b>  | 13c. CITY OR TOWN<br><b>Baltimore</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST <b>John</b> MIDDLE <b>Sommerville</b> LAST <b>Sommerville</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Nellie</b> MIDDLE <b>Bush</b> LAST <b>Bush</b>                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>213-05-0993</b>  |   | 17. INFORMANT<br><b>Mrs. Nancy Nadolny, 2102 Graythorn</b>                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Anemia</b><br><b>1552</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>CD of the Liver</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b> |  |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Diabetes</b>  |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>1 Dec</b> , 19 <b>81</b> , to <b>12 Jan</b> , 19 <b>82</b> , that (1) (we) last saw the deceased alive on <b>Jan 4</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.            |  |   |   |  |  |
| 22b. SIGNATURE<br><b>Harold H. B. B. B.</b>  |  | DEGREE<br><b>M.D.</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>1/13/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>1/15/82</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Park Cem.</b>                                       |  | 23d. LOCATION<br>CITY OR TOWN <b>Baltimore</b> COUNTY <b>Md.</b> STATE   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Zannino Funeral Home, 263 S. Conkling St</b>  |  |   | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>JAN 14 1982</b> <b>James J. Nathan</b> |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. For the purpose of this law, the death certificate is the one retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  |   | REG. NO.                                       |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FANNIE J. SOUTHARD   |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1 24 82 |   |  |  |  |
| 3. SEX<br>female  |  | 4. RACE<br>white  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>May 23, 1882  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>99 YRS.  |  | 7b. HOUR<br>3 <sup>28</sup> PM   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New Jersey   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore (city) MD.                                    |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Agnes Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>housewife                   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>own home  |  |
| 13a. STATE<br>New Jersey  |  | 13b. COUNTY<br>Camden   |  | 13c. CITY OR TOWN<br>Berlin   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>50 Summit Avenue  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Samuel Ireland  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Elizabeth Giffin   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>no  |  |   |  | 16b. SOCIAL SECURITY NO.<br>145-40-4922   |  | 17. INFORMANT ADDRESS<br>Wayne Southard 20 Woodlane Rd. 08648                                   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardio-respiratory arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>pneumonia / dehydration</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>right cerebrovascular accident</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>no</u> |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/20</u> 19 <u>82</u> to <u>1/24</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>1/24</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>Jerry D. Skarbek  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br>1/24/82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Jerry D. Skarbek   |  |   |  | 22e. ADDRESS<br>St. Agnes Hospital  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>burial   |  | 23b. DATE<br>1/28/82  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Berlin Cemetery   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Berlin Camden N.J.                                |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Ambrose Funeral Home  |  |   |  | ADDRESS<br>1328 Sulphur Spring Rd.  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 25 1982  |  | 25b. REGISTRAR'S SIGNATURE<br>Thomas J. Nathan   |  |

BP

15-2-1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4-111-1

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and certified, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |   |  |   |  |  |                    | 8 2 0 1 5 1 9  |  |
|---|--|---|--|---|--|---|--|--|--------------------|--|--|
| 1 - FOR STATE REGISTRAR   |  |   |  |   |  |   |  |  |                    | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>EVA Ruth SOUTHERLAND   |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>JANUARY 6, 1982  |  |  | 2b. HOUR<br>11:06A |  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>Negro  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Sept. 9-1911  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>70 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |                    | IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Va.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |  |  |                    |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>JOHNS HOPKINS HOSPITAL |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Domestic                    |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Private   |                    |  |  |
| 13a. STATE<br>Md.   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>1833 N. Castle St.  |                    |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Richard Stokes  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Hannah Jones   |  |   |  |  |                    |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  |   |  | 16b. SOCIAL SECURITY NO.<br>218-13-3758   |  | 17. INFORMANT ADDRESS<br>Oscar Sutherland 1833 N. Castle St.                                    |  |  |                    |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST<br>4589<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) HYPOTENSION<br>(c) HYPOXIA / SEIZURE    |  |   |  |   |  |   |  |  |                    | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>5 MIN<br>1 HR<br>1 1/2 HR  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br>CEREBRAL INSUFFICIENCY, HEART FAILURE, DIABETES, HISTORY OF PHLEBITIS   |  |   |  |   |  |   |  |  |                    |  |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                    | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |  |                    |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |                    |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from JULY 1980 to DEC 31, 1981 that (I) (we) last saw the deceased alive on DEC 15, 1981, and that it is (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. |  |   |  |   |  |   |  |  |                    |  |  |
| 22a. SIGNATURE<br>Steven T. Kariya  |  |   |  | DEGREE<br>MD<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>  |  |   |  | 22c. DATE SIGNED<br>JAN 8, 1982  |                    |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>STEVEN T. KARIYA   |  |   |  | 22e. ADDRESS<br>JOHNS HOPKINS HOSP., BALTIMORE MD 21205   |  |   |  |  |                    |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Removal  |  |   |  | 23b. DATE<br>1-8-82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Stokes Cemetery   |  | 23d. LOCATION<br>(CITY OR TOWN) COUNTY STATE<br>Crew Va.                             |                    |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Randolph J. Collick   |  |   |  | ADDRESS<br>2431 E. Oliver St.   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 8 1982  |                    | 25b. REGISTRAR'S SIGNATURE<br>Anne J. North  |  |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT - If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 5 2 0

REG. NO.

|  |  |  |  |   |  |   |  |  |  |
|--|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Harry James Spedden Sr.</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>1-45-82</b>                     |   |  | 2b. HOUR<br><b>3:50 P.M.</b>  |  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>12 20 07</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b> YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Baltimore, Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore City Hospitals</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>              |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Beth. Steel</b>  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>---</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>404 Cornwall Street 21224</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George Spedden Sr.</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anna</b>  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>212-09-1973</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Margaret E. Spedden 404 Cornwall Street</b>                      |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary embolus</b><br><b>4151</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:<br><b>COPD, coronary artery disease</b>   |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                         |   |  |  |  |
| 21d. INJURY OCCURRED<br>AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/19/80</b> to <b>1/25/82</b> , that (I) (we) last saw the deceased alive on <b>1/19/82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Franklin E. Chatham</b>   |  |  |  |   | DEGREE<br><b>M.D.</b>  |   | 22c. DATE SIGNED   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Franklin E. Chatham</b>  |  |  |  |   | 22e. ADDRESS   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>   |  |  | 23b. DATE<br><b>1-29-82</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sacred Heart of Mary</b>                                      |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Dundalk, Balto. Co. Md.</b> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>C.S. Zeiler &amp; Son Inc. 6224 Eastern Avenue</b>  |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>JAN 27 1982</b> <b>James Van Nuthen</b> |   |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the health department after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |                         |   |  | 8 2 0 1 5 2 1   |                           |
|---|-------------------------|---|--|---|---------------------------|
| 1. FOR STATE REGISTRAR  |                         |   |  | REG. NO.  |                           |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>FRANCIS A SPORNEY</b>  |                         |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JANUARY 17; 1982</b> |   | 2b. HOUR<br><b>2:40pm</b> |
| 3. SEX<br><b>male</b>   | 4. RACE<br><b>white</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4 9 98</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>83</b> YRS.   |                           |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                           |
| 9. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Church Home Hospital</b>              |  |   |                           |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>gas operator</b>   |                         | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>G &amp; E Co</b>  |  |   |                           |
| 13a. STATE<br><b>Maryland</b>   |                         | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN   |                           |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Ignatius Sporney</b>   |                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Julia Skotarski</b>   |  |   |                           |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>no</b>   |                         | 16b. SOCIAL SECURITY NO.<br><b>212 05 4500</b>  |  | 17. INFORMANT ADDRESS<br><b>Marlene Sniadach 6824 Boston Avenue</b>   |                           |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br>1991<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>ADENOCARCINOMA (UNKNOWN PRIMARY), HYPERCALCEMIA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |                         |   |  |   |                           |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |                         |   |  |   |                           |
| 19a. DATE OF OPERATION  |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                           |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                         | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  |   |                           |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                         | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |                           |
| 21d. INJURY OCCURRED<br>WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |                         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                           |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12-29</b> 19 <b>81</b> , to <b>1-17</b> 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>1-17</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.           |                         |   |  |   |                           |
| 22b. SIGNATURE<br><i>Sivan</i>  |                         | DEGREE<br><b>M-D</b>  |  | 22c. DATE SIGNED<br><b>1/17/82</b>  |                           |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>V. SIVAN MD.</b>  |                         | 22e. ADDRESS<br><b>CHURCH HOME CORP.<br/>100 NORTH BROADWAY BALTI; MD. 21231</b>  |  |   |                           |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |                         | 23b. DATE<br><b>1/21/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens Of Faith</b>   |                           |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md</b>   |                         | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Walter Dabrowski 1005 Dundalk Avenue</b>   |  |   |                           |
| 25a. DATE REC'D. BY REGISTRAR   |                         | 25b. REGISTRAR'S SIGNATURE<br><b>JAN 20 1982 Thomas Van Nuden</b>   |  |   |                           |



NOTION



NOTION

NOTION

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |   |  |   |  |   |  |
|---|--|---|---|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>DORIS MAE SPRIGGS</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 / 13 / 82</b> |   |  | 2b. HOUR<br><b>3 30 PM</b>  |  |   |  |
| 3. SEX<br><b>F</b>  |  | 4. RACE<br><b>B</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 10 20</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>61</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>MD</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD                                |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Good Samaritan Hospital</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>2000 Odell Avenue</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles Williams</b>   |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Josephine Mack</b>  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>218-18-7228</b>  |   | 17. INFORMANT ADDRESS<br><b>Delatour Spriggs 1901 Cecil Avenue</b>  |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>UREMIA END STAGE RENAL FAILURE</b><br>2500<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>HYPERTENSION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>DIABETES</b>  |  |   |   |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>AS ABOVE</b>   |  |   |   |   |  |   |  |   |  |
| 19a. DATE OF OPERATION<br><b>—</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>—</b>  |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>— P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>—</b>  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>—</b>  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>— Baltimore Co. MD</b>  |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/18</b> , 19 <b>81</b> , to <b>1/13</b> , 19 <b>82</b> , that (I) (we) lost<br>saw the deceased alive on <b>1/13</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |   |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Carlos Gonzalez</b>  |  |   |   | DEGREE<br><b>MD</b>   |  |   |  | 22c. DATE SIGNED<br><b>1/13/82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CARLOS GONZALEZ</b>   |  |   |   | 22e. ADDRESS<br><b>GOOD SAMARITAN HOSP.</b>   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>1/18/82</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co. MD</b>                           |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H</b>   |  |   |   | ADDRESS<br><b>1101 E. North Ave.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 14 1982</b>   |  |   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of death.

Smallmouth Bass 304 ft. MA.

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

|   |  |   |  |  |   |
|---|--|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>FIRST MIDDLE LAST</b><br><b>JOSEPH BARNUM SQUIRE</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1-26-82</b>                                |  | 2b. HOUR<br><b>6:08 AM</b>  |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>BLACK</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 27 12</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS.                                      | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>NL</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD                       |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BON SECOURS HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK OR MOST OF WORKING LIFE)<br><b>ROTHSCHILD</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>POOL</b>  |
| 13a. STATE<br><b>MD</b>   |  |   | 13b. COUNTY<br><b>Baltimore</b>  | 13c. CITY OR TOWN<br><b>Baltimore</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOHN SQUIRE</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>COHA</b>                         |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>246-10-3204</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>PAULINE THOMAS 1507 W. Sassauga St</b>                  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO - RESPIRATORY ARREST</b><br><b>5724</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>HEPATO RENAL SYNDROME</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>RENAL INSUFFICIENCY; C.H.F.; CIRRHOSIS.</b>   |  |   |  |  |   |
| 19a. DATE OF OPERATION<br>____  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>____  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>              |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19 <b>82</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br>____ |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>____  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>____                              |   |
| 22a. I certify that <del>at</del> (this hospital) attended the deceased from <b>1/25</b> 19 <b>82</b> to <b>1/26</b> 19 <b>82</b> , that I <del>viewed</del> saw the deceased alive on <b>1/26</b> 19 <b>82</b> , and that in <del>my</del> <b>my</b> opinion death occurred on the date and hour and from the causes stated above, <del>and I did not</del> (did not) view the body after death.         |  |   |  |  |   |
| 22b. SIGNATURE<br><b>Howard B. Chen</b> DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  |   |  | 22c. DATE SIGNED<br><b>1/26/82</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HOWARD B. CHEN</b>  |  | 22e. ADDRESS<br><b>BON SECOURS HOSPITAL</b>   |  |  |   |
| 23a. FUNERAL, CREMATION, REMOVAL<br>(IF BY)<br><b>Burial</b>  |  | 23b. DATE<br><b>1/30/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt Airy</b>                                   |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore MD</b>   |  | 25a. DATE REC'D BY REGISTRAR<br><b>JAN 27 1982</b>  |  |  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Maryann 638 8914</b>   |  |   |  |  |   |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified and the body must be retained for autopsy.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Posing may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |  |  |   |  |  |   | 8  | 2   | 0 | 1  | 5                        | 2  | 4 |   |  |
|--|--|--|--|--|--|---|--|--|---|--|---|---|--|--------------------------|--|---|---|--|
| CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |  |   | REG. NO.   |   |   |  |                          |  |   |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARTIN STAFFORD</b>   |  |  |  |  |  |   |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 22 82</b>  |   |   |  | 2b. HOUR<br><b>11 AM</b> |  |   |   |  |
| 3. SEX<br><b>MALE</b>  |  |  | 4. RACE<br><b>BLACK</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 - 6 - 1900</b>           |   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b> YRS.  |   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |   | IF UNDER 24 HRS.   |                          |  |   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>LINAS ROAD MD.</b>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b> |  |   |   |  |                          |  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>DEATON MED. CENTER</b> |  |  |   |  |  |   |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR 6 MONTHS OR MORE OF LIFE)<br><b>Retired Sec</b> |                          | 12b. KIND OF BUSINESS OR INDUSTRY              |   |   |  |
| 13a. STATE<br><b>MARYLAND</b>  |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                                |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 13e. STREET ADDRESS<br><b>940 N. Durham Street</b>   |   |   |  |                          |  |   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>LINCOLN STAFFORD</b>  |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>JULIA SPICER</b> |   |  |  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>   |   |   |  |                          | 16b. SOCIAL SECURITY NO.<br><b>217-03-9884</b> |   | 17. INFORMANT<br>ADDRESS<br><b>CARTIE REED 6960 LINDEN AVE. 21227</b> |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>SEPSIS</b><br>4860<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>PNEUMONIA</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)       |  |  |  |  |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 DAYS</b><br><b>4 DAYS</b>   |   |   |  |                          |  |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>G.I. BLEED</b>  |  |  |  |  |  |   |  |  |   |  |   |   |  |                          |  |   |   |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |   |  |                          |  |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |   |  |   |   |  |                          |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |  |   |   |  |                          |  |   |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>1/12</b> , 19 <b>82</b> , to <b>1/22</b> , 19 <b>82</b> , that (1) (we) lost saw the deceased alive on <b>1/22</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did not view the body after death. |  |  |  |  |  |   |  |  |   |  |   |   |  |                          |  |   |   |  |
| 22b. SIGNATURE<br><b>Donald R. Lurye, MD</b>   |  |  |  |  |  | DEGREE<br><b>MD</b>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>1/22/82</b>   |   |   |  |                          |  |   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DONALD R. LURYE, MD</b>  |  |  |  |  |  | 22e. ADDRESS<br><b>DEATON MED. CTR. 611 So. CHARLES ST., BALTO, MD</b>  |  |  |   |  |   |   |  |                          |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  |  |  | 23b. DATE<br><b>1-28-82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LINAS Rd Cemetery</b>  |  |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Dorchester Co. Md.</b>  |   |   |  |                          |  |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>William J. Spicer</b>   |  |  |  |  |  | ADDRESS<br><b>1639 N. Broadway</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 25 1982</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>James J. Anthony</b>  |   |   |  |                          |  |   |   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8 2 0 1 5 2 5  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |   |  | REG. NO.   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST MIDDLE LAST<br>RAYMOND STAFFORD   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>1/23/82  |  | 2b. HOUR<br>5:30 PM   |  |
| 3 SEX<br>MALE  |  | 4 RACE<br>BLACK   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>11 14 02  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>79 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>US  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE City MD   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>LUTHERAN HOSPITAL |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HELPER  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>MOVING VAN   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13a. STATE<br>MD  |  | 13b. COUNTY<br>---   |  | 13c. CITY OR TOWN<br>BALTIMORE  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>SAMUEL SPROW  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>LIZA STAFFORD   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br>1605 BRUCE CT.<br>21217  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO<br>218 03 8808<br>218 038 808   |  | 17. INFORMANT<br>IRENE E. DIXON 2212 DEERFERN<br>CRESCENT, BALTO., MD. 21209   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) Sepsis<br>5908<br>DUE TO, OR AS A CONSEQUENCE OF (b) Pyrexia<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from 11/23/81 to 1-23-82, that (1) (we) lost saw the deceased alive on 1/23/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.                               |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br>Siss As Anwa   |  | DEGREE<br>MD  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>       |  | 22c. DATE SIGNED<br>1/23/82   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS<br>Lutheran Hospital   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>CREMATION   |  | 23b. DATE<br>1/25/1981  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>GREEN MOUNT CREMATORY  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>BALTIMORE MARYLAND   |  |
| 24. FUNERAL DIRECTOR<br>WALTER BROOKS BRADLEY INC., BALTO., MD. 21222  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 27 1982   |  | 25b. REGISTRAR'S SIGNATURE<br>James J. Kistner  |  |

2.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| FOR STATE REGISTRAR  |  |  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 8 2 0 1 5 2 6  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  |  | 2a. DATE OF DEATH  |  |  |  | 2b. HOUR   |  |  |  |
| BEATRICE STATEN  |  |  |  | Jan 11 82  |  |  |  | 622A M   |  |  |  |
| 3 SEX  |  | 4 RACE   |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS  |  |
| F  |  | BLK  |  | 7-4-10   |  | 71 YRS.  |  | MONTHS   |  | DAYS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |  |  |  |  |
| N.C.   |  | U.S.A.   |  |  |  | CITY MD.   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                  |  | 12b. KIND OF BUSINESS OR INDUSTRY                        |  |  |  |
| BALTO  |  | PROV. Hosp   |  |  |  |  |  |  |  |  |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?   |  | 13e. STREET ADDRESS                                      |  |  |  |
| MD   |  |  |  | BALTO  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 815 Dukeland Ave. Glen Hill House 19                     |  |  |  |
| 14. FATHER'S NAME  |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |  |  |
| FIRST MIDDLE LAST  |  |  |  | FIRST MIDDLE LAST  |  |  |  |  |  |  |  |
| SAMUEL   |  |  |  | Barnett  |  |  |  | Katie Easter   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |  |  |  |  |  |
| No   |  |  |  |  |  | Dorothy Bridgley 815 Dukeland Ave  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |  |
| IMMEDIATE CAUSE (a) Electromechanical dissociation   |  |  |  |  |  |  |  |  |  |  |  |
| 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Acute myocardial infarction  |  |  |  |  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |  |  |  |  |  |  |  |  |
| Congestive heart failure   |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |  |  |  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |  |  |
|  |  |  |  | HOUR A.M. MONTH DAY YEAR   |  |  |  |  |  |  |  |
|  |  |  |  | P.M. 19  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION  |  |  |  |  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  |  |  | STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from 1-7-1982, to 1-11-1982, that (1) <del>times</del> last saw the deceased alive on 1-11-1982, and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (1) <del>time</del> (did) <del>not</del> view the body after death. |  |  |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE   |  |  |  | DEGREE   |  |  |  | 22c. DATE SIGNED   |  |  |  |
| Juan C. Ruffier  |  |  |  | MD   |  |  |  | 1-11-82  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | 22e. ADDRESS   |  |  |  |  |  |  |  |
| JUAN C. RUFFIER MD   |  |  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION  |  |  |  |
| Burial   |  |  |  | 1/16/82  |  | Arbutus  |  | CITY OR TOWN COUNTY STATE                                |  |  |  |
|  |  |  |  |  |  |  |  | BALTO MD   |  |  |  |
| 24. FUNERAL DIRECTOR   |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  |  |  |  |  |
| NAME ADDRESS   |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |  |  |
| Vernon Bailey 1348 Calhoun St  |  |  |  |  |  | JAN 18 1982 [Signature]  |  |  |  |  |  |

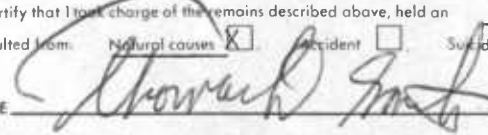

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

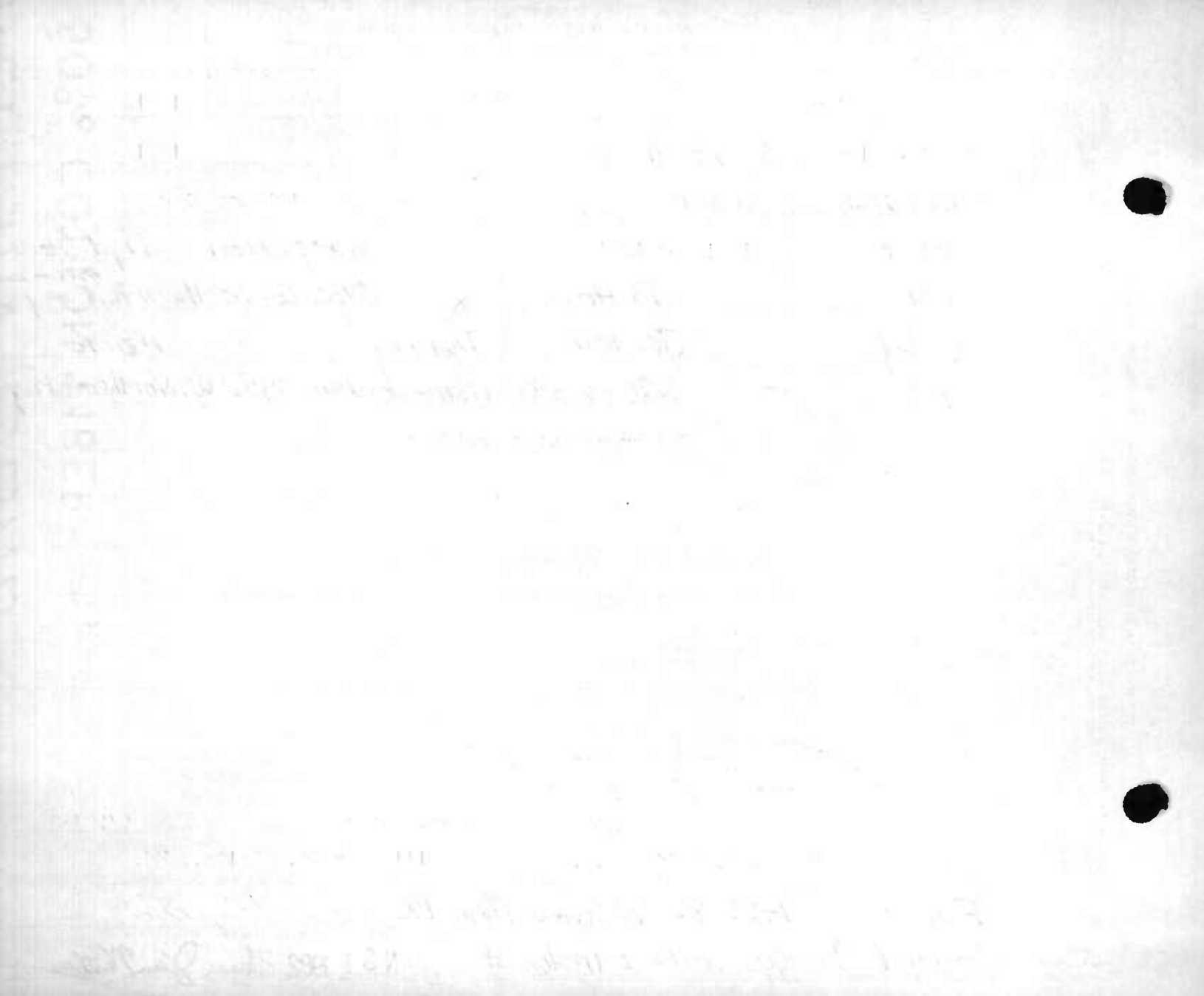
DHMH-17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|   |  |                         |  |  |  |  |  |   |  |   |  |   |  |   |  |  |  |
|---|--|-------------------------|--|--|--|--|--|---|--|---|--|---|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 3 2 0 1 5 2 7           |  |  |  |  |  |   |  |   |  |   |  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Joyce Staten</b>   |  |                         |  |  |  |  |  |   |  | 2a. DATE KNOWN<br>OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR <b>1 18 1982</b>                                 |  | 2b. HOUR<br><b>9:20</b>   |  |   |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Black</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>3-19-41</b>  |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY YRS. <b>40</b>          |  | IF UNDER 1 YR.<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.  |  | 2c. DATE<br>PRONOUNCED<br>DEAD MONTH DAY YEAR <b>1 18 1982</b>                                  |  | 2d. HOUR<br><b>9:20</b>                                 |  |  |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY) <b>Maryland</b>  |  |                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City,</b> MD.                              |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  |                         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Sinai Hospital</b> |  |  |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE) <b>Salesperson</b>   |  |   |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY <b>Dept. Store</b> |  |  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |                         |  | 13a. STATE <b>md.</b>  |  |  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN <b>Balto.</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <b>3952 W. Northern Parkway</b>     |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>Wiley Jordan</b>  |  |                         |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Dabney Marie</b>  |  |  |  |   |  |   |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>No</b>   |  |                         |  | 16b. SOCIAL SECURITY NO. <b>220-36-3300</b>  |  |  |  | 17. INFORMANT ADDRESS <b>Marie Jordan 3952 W. Northern Pkwy</b>   |  |   |  |   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |                         |  |  |  |  |  |   |  |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH         |  |  |  |
| PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b><br>4360<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a) stating the under-<br>lying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |                         |  |  |  |  |  |   |  |   |  |   |  |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.   |  |                         |  |  |  |  |  |   |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  |   |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |  |   |  |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)   |  |   |  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |                         |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)   |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion<br>death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                         |  |  |  |  |  |   |  |   |  |   |  |   |  |  |  |
| ACTUAL<br>SIGNATURE    |  |                         |  | TITLE (SPECIFY) <b>Deputy Chief</b> MEDICAL EXAMINER   |  |  |  |   |  |   |  | DATE<br>SIGNED <b>1/19/82</b>   |  |   |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT) <b>Thomas D. Smith, M.D.</b>   |  |                         |  | ADDRESS <b>111 Penn St. Balto., Md.</b>  |  |  |  |   |  |   |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE) <b>Burial</b>   |  |                         |  | 23b. DATE <b>1-22-82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Westview Mem. Pk</b> |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>Balto., Md.</b>   |  |   |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Calvin B. Scruggs</b> ADDRESS <b>1412 E. Preston St.</b>  |  |                         |  |  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>JAN 21 1982</b> 25b. REGISTRAR'S SIGNATURE  |  |   |  |   |  |  |  |

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DEATH RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |         |   |  |  |  |   |  |   |  |                          |  |  |  |
|--|---------|---|--|--|--|---|--|---|--|--------------------------|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         | FIRST   |  | MIDDLE   |  | LAST  |  | 2a. DATE KNOWN OF DEATH   |  | XX MONTH DAY YEAR        |  | 2b. HOUR                                     |  |
| Stanley Milton Staub Jr.   |         |   |  |  |  |   |  | 1 23 19 82  |  |                          |  | M  |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YR.  |  | IF UNDER 24 HRS.  |  | 2c. DATE PRONOUNCED DEAD |  | 2d. HOUR                                     |  |
| male   | white   | Dec. 24, 1920   |  | 61 YRS.  |  |   |  |   |  | 1 23 19 82               |  | 12:04  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |   |  |                          |  | PM   |  |
| Pa.  |         | USA   |  |  |  | Baltimore City  |  |   |  |                          |  | MD.  |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |   |  |                          |  |  |  |
| Baltimore  |         | Union Memorial Hospital   |  | Painter-Md. Training School  |  |   |  |   |  |                          |  |  |  |
| 13a. STATE   |         | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS   |  |                          |  |  |  |
| Md.  |         |   |  | Baltimore  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 4608 Renwick Avenue   |  |                          |  |  |  |
| 14. FATHER'S NAME  |         | 15. MOTHER'S MAIDEN NAME  |  |  |  |   |  |   |  |                          |  |  |  |
| Stanley M. Staub Sr.   |         | Sarah Harner  |  |  |  |   |  |   |  |                          |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |         | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT  |  | ADDRESS   |  |   |  |                          |  |  |  |
| yes  |         | WW 2  |  | 168-14-3085  |  | Mrs. Patricia L. Hoover   |  | 2310 Delight Aquila's   |  |                          |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         |   |  |  |  |   |  |   |  |                          |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I DEATH WAS CAUSED BY:  |         |   |  |  |  |   |  |   |  |                          |  |  |  |
| 4029 IMMEDIATE CAUSE (a) Hypertensive cardiovascular disease   |         |   |  |  |  |   |  |   |  |                          |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |   |  |  |  |   |  |   |  |                          |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |         |   |  |  |  |   |  |   |  |                          |  |  |  |
| (b)  |         |   |  |  |  |   |  |   |  |                          |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |   |  |  |  |   |  |   |  |                          |  |  |  |
| (c)  |         |   |  |  |  |   |  |   |  |                          |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |         |   |  |  |  |   |  |   |  |                          |  |  |  |
| 19a. DATE OF OPERATION   |         |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  | 20. AUTOPSY?  |  |                          |  |  |  |
|  |         |   |  |  |  |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                      |  |                          |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         |   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |                          |  |  |  |
|  |         |   |  | P.M. 19  |  |   |  |   |  |                          |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |         |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |   |  | 21f. LOCATION   |  |                          |  |  |  |
|  |         |   |  |  |  |   |  | CITY OR TOWN COUNTY STATE   |  |                          |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |         |   |  |  |  |   |  |   |  |                          |  |  |  |
| ACTUAL SIGNATURE   |         |   |  | TITLE (SPECIFY)  |  |   |  | DATE SIGNED   |  |                          |  |  |  |
| Margarita A. Korell, M.D.  |         |   |  | M.D. Assistant   |  |   |  | 1/24/82   |  |                          |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |         |   |  | ADDRESS  |  |   |  |   |  |                          |  |  |  |
| Leonard J. Ruck Inc. Baltimore, Maryland   |         |   |  | 111 Penn Street, Balto, MD 21201   |  |   |  |   |  |                          |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SP-1)   |         |   |  | 23b. DATE  |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |                          |  |  |  |
| Burial   |         |   |  | Jan. 26, 1982  |  |   |  | Meadowridge Memorial  |  |                          |  |  |  |
| 24. FUNERAL DIRECTOR NAME  |         |   |  | 25a. DATE REC'D. BY REGISTRAR  |  |   |  | 25b. REGISTRAR'S SIGNATURE  |  |                          |  |  |  |
| Leonard J. Ruck Inc. Baltimore, Maryland   |         |   |  | JAN 25 1982  |  |   |  | Charles J. Nathan   |  |                          |  |  |  |

JAN 25 1982



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove card page 3 and 4 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 5 2 9

REG. NO.

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Angela Christine Steele</b>  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>01/04/82</b>   |  | 2b. HOUR<br><b>12:53p</b>  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Caucasian</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 22, 1978</b>   |  |
| 6. AGE<br>(IN YEARS LAST BIRTHDAY)<br><b>3</b>  |  | 7. BIRTHPLACE<br>(STATE OR FOREIGN)<br><b>Virginia</b>   |  | 8. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 9. BIRTHPLACE<br>(STATE OR FOREIGN)<br><b>Virginia</b>  |  | 10. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 11. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  |
| 12. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Johns Hopkins Hospital</b> |  | 14. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>None</b>   |  |
| 15. USUAL RESIDENCE<br>(IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>15a. STATE<br><b>Virginia</b>   |  | 15b. COUNTY<br><b>Augusta</b>  |  | 15c. CITY OR TOWN<br><b>Stanton</b>  |  |
| 16. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 17. STREET ADDRESS<br><b>924 Nelson St., Apt. 2</b>  |  | 18. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Florence C. Tucker</b>   |  |
| 19. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William C. Steele</b>  |  | 20. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 21. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>N/A</b>   |  |
| 22. INFORMANT<br><b>Eleanor MacQueen, John Hopkins Hospital</b>   |  | 23. ADDRESS<br><b>Johns Hopkins Hospital</b>   |  | 24. CAUSE OF DEATH<br>(Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiorespiratory failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>citruellinemia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>hyperammonemia</b> |  |
| 25. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b>   |  | 26. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 1/2 years</b>   |  | 27. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 days</b>  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/2/81</b> , 19 <b>82</b> , to <b>1/4</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>1/4</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |
| 22b. SIGNATURE<br><b>C Schwartz</b>   |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>1/4/82</b>  |  |
| 22d. PHYSICIAN'S NAME<br>(TYPE OR PRINT)<br><b>C Schwartz</b>   |  | 22e. ADDRESS<br><b>Johns Hopkins Hospital Baltimore</b>  |  | 22f. ADDRESS   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>1/8/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>THORNROSE CEMETERY</b>  |  |
| 23d. LOCATION<br><b>STAUNTON, AUGUSTA CO. VA.</b>   |  | 23e. NAME OF CEMETERY OR CREMATORY   |  | 23f. LOCATION  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Thomas E. Fisher</b>   |  | 24b. ADDRESS<br><b>WOODLAWN MEMORIAL FH<br/>6411 Windsor Mill Rd.</b>  |  | 25. DATE OF DEATH<br><b>JAN 8 1982</b>   |  |
| 25a. DATE OF DEATH<br><b>JAN 8 1982</b>   |  | 25b. SIGNATURE<br><b>Thomas E. Fisher</b>  |  | 25c. SIGNATURE   |  |

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of the

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52# Weston 100

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1, 2, and 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1, 2, and 3 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH-16 30M 2/80  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |   |   |                               |  |
|---|--|---|--|---|--|---|---|---|-------------------------------|--|
| 1. FOR STATE REGISTRAR  |  |   |  |   | REG. NO.   |   |   |   |                               |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MICHAEL P. STEFANKO</b>  |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR <b>JANUARY 27, 1982</b>                           |   |   |   |                               |  |
| 3. SEX <b>Male</b>  |  |   |  |   | 2b. HOUR <b>4:04PM</b>   |   |   |   |                               |  |
| 4. RACE <b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov. 7, 1961</b>   |  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>20</b> YRS.                                  |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                 |   | IF UNDER 74 HRS<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pa.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |   |   |                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b> |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Student</b> |   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>-----</b>   |                               |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |   |  |   |   |   |                               |  |
| 13a. STATE<br><b>Pa.</b>  |  | 13b. COUNTY<br><b>Ridley Park</b>   |  | 13c. CITY OR TOWN<br><b>Ridley Park</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>510 E. Ridley Ave.</b>  |                               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Stephen J. Stefanko</b>  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Nancy Feeney</b>               |   |   |   |                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>  |  |   |  |   | 16b. SOCIAL SECURITY NO.<br><b>194 54 8864</b>                                     |   | 17. INFORMANT ADDRESS<br><b>White Funeral Home, Ridley Park, Pa.</b>      |   |                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiorespiratory arrest</b><br>7598<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>sepsis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>aplasia</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1/27, 4:04 PM</b><br><b>1/25/82</b><br><b>1/25/82</b> |  |   |  |   |  |   |   |   |                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |  |   |  |   |   |   |                               |  |
| MEDICAL CERTIFICATION   |  |   |  |   |  |   |   |   |                               |  |
| 19a. DATE OF OPERATION<br><b>-----</b>  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>-----</b>       |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                      |                               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)     |   |   |   |                               |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                  |   |   |   |                               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>January 26, 1982</b> , to <b>January 27, 1982</b> , that (I) (we) last saw the deceased alive on <b>January 27, 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. <b>4:04 PM</b>  |  |   |  |   |  |   |   |   |                               |  |
| 22b. SIGNATURE<br><b>Kenneth Ellenbogen MD</b>  |  |   | 22c. DATE SIGNED<br><b>1/27/82</b>                                     |   |  |   |   | 22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                               |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Kenneth Ellenbogen</b>  |  |   | 22f. ADDRESS<br><b>Johns Hopkins Hospital</b>                          |   |  |   |   |   |                               |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Removal</b>   |  |   | 23b. DATE<br><b>1/30/82</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>SS. Peter &amp; Paul</b>                  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Marple Township, Pa.</b> |   |                               |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Henry W. Jenkins &amp; Sons Co.</b><br>ADDRESS <b>4905 York Road Balto., Md. 21212</b>  |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 1 1982</b>                                 |   | 25b. REGISTRAR'S SIGNATURE<br><b>James J. Martin</b>                      |   |                               |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |  |                                    | REG. NO.                                     |  |
|--|--|---|--|---|--|---|--|--|------------------------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>RAYMOND M. STEIN</b>   |  |   |  |   | 7a. DATE OF DEATH MONTH DAY YEAR<br><b>01 23 82</b>                    |   |  | 7b. HOUR<br><b>10<sup>30</sup> PM</b>  |                                    |  |  |
| 3. SEX<br><b>M MALE</b>  |  | 4. RACE<br><b>CAUCASIAN</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>09 01 1916</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>65</b> <del>66</del> YRS                                  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |                                    |  |  |
| 8. BIRTHPLACE (COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |  |                                    |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>MANAGER</b>                 |  | 12b. KIND OF INDUSTRY<br><b>EDGEWATER MENS SHOP</b>  |                                    |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>BALTO</b>   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>APT. T-2 #21215<br/>6962 WILBROOK PARK DR</b>  |                                    |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>BERYL STEIN</b>  |  |   |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>KATE LOVE</b>         |   |  |  |                                    |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>YES</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>WW 71 I-ARMY</b>   |  | 17. INFORMANT<br><b>MRS. SOHIE STEIN</b>  |  | 17. ADDRESS<br><b>6962 MILBROOK PARK DR., APT. T-2 #21215</b>                                   |  |  |                                    |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>1912</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>S/P ASTROCYTOMA GRADE 3-4 (2) TEMPORAL</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>temporal</b>                                  |  |   |  |   |  |   |  |  |                                    | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |   |  |   |  |   |  |  |                                    |  |  |
| 19a. DATE OF OPERATION<br><b>11/11/81</b>  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>(2) TEMPORAL GLIOMA</b> |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                    |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                 |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |  |                                    |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)            |   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |                                    |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I was (did not) view the body after death. |  |   |  |   |  |   |  |  |                                    |  |  |
| 22a. SIGNATURE<br><i>M. Abraham</i> 9/4/1  |  |   |  |   | DEGREE   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1/23/82</b> |  |  |
| 22a. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MENACHEM ABRAHAM, M.D.</b>   |  |   |  |   | 22b. ADDRESS<br><b>SINAI HOSH - BALTO., MD</b>                         |   |  |  |                                    |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  |   | 23b. DATE<br><b>JAN. 25, 1982</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BETH YEHUDA ANSHE KURLAND</b> |   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b>   |                                    |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b>   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 27 1982</b>   |  |  |                                    |  |  |
| 24. ADDRESS<br><b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>   |  |   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><i>James Van Natten</i>   |  |  |                                    |  |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |   |  |   |   |                   | 8 2 0 1 5 3 2                                |  |
|---|--|---|--|---|---|--|---|---|-------------------|--|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO.  |  |   |   |  |   |   |                   |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Margaret Stewart   |  |   |  |   |   | 2a. DATE OF DEATH<br>Jan 15, 1982  |   |   | 2b. HOUR<br>4:45p |  |  |
| 3 SEX<br>FEMALE   |  | 4 RACE<br>NEGROID   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Sept. 6, 1906   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>75 YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS  |                   | IF UNDER 24 HRS.<br>HOURS MIN.               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City                               |   |   | MD.               |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTO.   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>The Johns Hopkins Hospital |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife        |   | 12b. KIND OF BUSINESS OR INDUSTRY   |                   |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |   |   | 13a. STATE<br>Md.  |   | 13b. COUNTY   |                   | 13c. CITY OR TOWN<br>BALTO.                  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>? WALLACE   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>SARAH JOHNSON  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 13e. STREET ADDRESS<br>1716 N. CAROLINE ST.  |   |   |                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>220-38-9527  |  | 17. INFORMANT<br>ADDRESS<br>JAMES STEWART 1716 N. CAROLINE ST.  |   |  |   |   |                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory arrest</u><br>1921<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Advanced carcinoma of meningitis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |   |   |  |   |   |                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Cancer, unknown primary</u>   |  |   |  |   |   |  |   |   |                   |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |                   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |   |                   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |   |                   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/15/81</u> , 19 <u>81</u> , to <u>1/15</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>4/40/11/82</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                        |  |   |  |   |   |  |   |   |                   |  |  |
| 22b. SIGNATURE<br>Oliver S. Schenck M.D.  |  |   |  |   |   | DEGREE<br>M.D.   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                   | 22c. DATE SIGNED<br>1/15/82.                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Oliver Schenck   |  |   |  |   |   | 22e. ADDRESS<br>Johns Hopkins Hospital   |   |   |                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |   | 23b. DATE<br>1-20-82   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Zion Meth. Ch. Cem. |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore City Maryland |   |                   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>CALVIN B. SCRUGGS   |  |   |  |   |   | ADDRESS<br>1412 E. Preston St.   |   | 25a. DATE REC'D BY REGISTRAR<br>JAN 18 1982   |                   | 25b. REGISTRAR'S SIGNATURE<br>[Signature]    |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 5 3 3

FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |   |                            |  |
|---|--|---|---|---|----------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>HENRY X. STIELPER</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 20 82</b> |   | 2b. HOUR<br><b>1:45 PM</b> |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec. 15, 1895</b>  |                            |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b>  |  | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |   | 8. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |                            |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>   |  | 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNION MEMORIAL HOSPITAL</b> |                            |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Office Mgr.</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Construction</b>  |   | 13a. STREET ADDRESS<br><b>Balt., Md. 21214</b>  |                            |  |
| 13b. COUNTY<br><b>Maryland</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George Stielper</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Wilhemina Schilpp</b>   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |                            |  |
| 16b. SOCIAL SECURITY NO.<br><b>212-05-9313</b>  |  | 17. INFORMANT<br><b>Daughter: Carolyn Hyatt</b>   |   | ADDRESS<br><b>Balt., Md. 21218</b>  |                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>GI Bleed</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>? CA lung</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>? Temporal arteritis</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |   |   |                            |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).   |  |   |   |   |                            |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                            |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |                            |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  | 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                            |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  | 22a. I certify that (I) (this hospital) attended the deceased from <b>12/15</b> , 19 <b>81</b> , to <b>1/20</b> , 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>1/20</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   | 22b. SIGNATURE<br><b>Brian H. Kahn, M.D.</b>  |                            |  |
| 22c. DATE SIGNED<br><b>1/20/82</b>  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |   | 22e. ADDRESS  |                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>Jan 25 1982</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Meadowridge Memorial</b>   |                            |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Dorsey Maryland</b>  |  | 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J. Ruck, Inc.</b>  |   | 25. DATE REC'D. BY REGISTRAR<br><b>JAN 22 1982</b>  |                            |  |
| 25b. REGISTRAR'S SIGN<br><b>Frances San Nathan</b>  |  |   |   |   |                            |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. The permit should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

DHMH-16 30M 2/80  
(VRA 15, 4)

Released as non-med per De Smith/ by Purvis

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 8 2 0 1 5 3 4  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  | REG. NO.   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>John A. Stokes   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>01/25/82  |  |  |  |
| 3 SEX<br>Male   |  | 4 RACE<br>Black   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1 12 25  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>57   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>VA   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.  |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Johns Hopkins Hospital |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD  |  |   |  | 13b. COUNTY<br>Baltimore   |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>James A. Stokes   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>MIDDLE LAST<br>Lillie Hurt   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes   |  | 16b. SOCIAL SECURITY NO.<br>225-24-9190   |  | 17 INFORMANT ADDRESS<br>Albert Stokes 1417 E. Lanvale St.  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>4275 IMMEDIATE CAUSE (a) CARDIAC ARREST<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/25, 19 82, to 1/25, 19 82, that (I) (we) lost<br>saw the deceased alive on 1/25, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death.                |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br>Vladimir Svesko MD  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>       |  | 22c. DATE SIGNED<br>1/25/82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>VLADIMIR SVESKO MD   |  |   |  | 22e. ADDRESS<br>Johns Hopkins Hospital   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE OR PRINT)<br>Burial  |  | 23b. DATE<br>1/29/82  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Md. Veteran Cem.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Crownsville MD   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H 1101 E. North Ave.   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 26 1982   |  | 25b. REGISTRAR'S SIGNATURE<br>Frances VanNathan  |  |

RECEIVED  
JAN 30 1953

U.S. DEPARTMENT OF AGRICULTURE

WASHINGTON, D.C.

Box 3

JAN 30 1953



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please detach for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed within 72 hours of filing with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|---|--|
| FOR<br>1. STATE<br>REGISTRAR  |  | REG. NO.  |  |   |  |   |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST<br>Frank  |  | MIDDLE<br>S   |  | LAST<br>Stover  |  | 20. DATE OF DEATH   |  |
|   |  |   |  |   |  |   |  | MONTH DAY YEAR  |  |
|   |  |   |  |   |  |   |  | 1 31 82   |  |
| 3. SEX<br>M Male  |  | 4. RACE<br>W White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>March 31, 1898  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>83 YRS.  |  | 2b. HOUR<br>3:30 M  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Virginia  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Good Samaritan Hospital            |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Engineer                    |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>P.R.R.   |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>Balt., Md. 21214<br>3023 Overland Avenue   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John W. Stover  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Carrie Lee Fox   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>A 716-12-3833   |  | 17. INFORMANT<br>Wife: Anna E. Stover<br>ADDRESS Balt., Md. 21214<br>3023 Overland Ave.                                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  |  |   |  |   |  |   |  |   |  |
| PART 1. DEATH WAS CAUSED BY:  |  |   |  |   |  |   |  |   |  |
| IMMEDIATE CAUSE (a) Respiratory arrest -  |  |   |  |   |  |   |  |   |  |
| 5570  |  |   |  |   |  |   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |   |  |   |  |   |  |
| (b) Sepsis  |  |   |  |   |  |   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |   |  |   |  |   |  |
| (c) Mesenteric thrombosis   |  |   |  |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION<br>1/26/82   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Mesenteric thrombosis   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/26 to 1/31, 1982, that (I) (we) lost<br>saw the deceased alive on 1/31, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br>H.O. Anna   |  | DEGREE<br>MD  |  | 22c. DATE SIGNED<br>1/31/82   |  |   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Howhamed ANNOUN  |  |
| 22e. ADDRESS<br>5601 Loch Row   |  | 22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>Feb 3 1982   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Quickel Church Cem.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>York Penna.                                       |  | 24. FUNERAL DIRECTOR<br>NAME<br>Leonard J. Ruck, Inc.   |  |
| 25a. DATE REC'D. BY REGISTRAR<br>FEB 1 1982   |  | 25b. REGISTRAR'S SIGNATURE<br>Rene Jan Norton   |  |   |  |   |  |   |  |



STATE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 8 2 0 1 5 3 6   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1- STATE REGISTRAR  |  |  |  | CERTIFICATE OF DEATH  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  |  | 2a. DATE OF DEATH   |  |  |  |
| Raymond L Strickler   |  |  |  | 01 04 82  |  |  |  |
| 3. SEX<br>Male  |  |  |  | 7b. HOUR<br>9:11a   |  |  |  |
| 4. RACE<br>White  |  |  |  | 7c. DATE OF DEATH MONTH DAY YEAR  |  |  |  |
| 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 21 1900   |  |  |  | 7d. DATE OF DEATH MONTH DAY YEAR  |  |  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>81 YRS.  |  |  |  | 7e. HOUR  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Ohio   |  |  |  | 7f. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |  |  |
| 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |  |  | 7g. IF UNDER 24 HRS<br>MONTHS DAYS HOURS MIN.   |  |  |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore CITY MD.  |  |  |  |
| 9. CITY OR TOWN OF DEATH<br>Baltimore   |  |  |  | 10. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Johns Hopkins Hospital |  |  |  |
| 11. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>11a. STATE<br>Maryland   |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Roll Setter   |  |  |  |
| 11b. CITY OR TOWN<br>Baltimore  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Beth. Steel  |  |  |  |
| 11c. CITY OR TOWN<br>Dundalk  |  |  |  | 13a. STREET ADDRESS<br>7725 Charlesmont Road  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Alfred E. Strickler   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Leveda Postelwaite   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No  |  |  |  | 16b. SOCIAL SECURITY NO.<br>213-07-8132   |  |  |  |
| 17. INFORMANT<br>Helen E. Strickler   |  |  |  | ADDRESS 7725 Charlesmont Rd.<br>Balto. MD 21222   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u><br>4960<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Chronic obs for disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>VERTICAL ARRYTHMIA</u>  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 HRS<br>2 HRS  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><u>VERTICAL ARRYTHMIA</u>   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>          |  |  |  |
| 21a. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  | 21d. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  |  |
| 21e. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>JAN 3</u> , 19 <u>82</u> , to <u>JAN 4</u> , 19 <u>82</u> , that (I) (we) lost<br>saw the deceased alive on <u>JAN 4</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Philus</u>   |  |  |  | 22c. DATE SIGNED<br>JAN 4 - 82  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>MICHAEL</u>   |  |  |  | 22e. ADDRESS<br>Johns Hopkins Hospital  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |  |  | 23b. DATE<br>1/7/82   |  |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br>Meadowridge Mem. Park   |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Dorsey Howard Maryland  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Duda-Ruck, Inc.   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 6 1982   |  |  |  |
| 25b. REGISTRAR'S SIGNATURE<br>7922 Wise Avenue, Dundalk, MD 21222   |  |  |  | 25c. REGISTRAR'S SIGNATURE<br>James J. Nathan   |  |  |  |



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 OF THIS FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DEPARTMENT OF HEALTH, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE. DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| Items 8 13a-e per phone 2/2/82 STATE OF MARYLAND   |  |   |   |   |                                    |   |                        |  |  |  |
|--|--|---|---|---|------------------------------------|---|------------------------|--|--|--|
| 1- STATE REGISTRAR #8, FilmG596 10/11/84 kam   |  |   |   |   |                                    |   |                        |  |  |  |
| DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |   |   |                                    |   |                        |  |  |  |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |   |   |   |                                    |   |                        |  |  |  |
| REG. NO. 5 2 0 1 5 3 7   |  |   |   |   |                                    |   |                        |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   | FIRST<br>Earl   |   |                                    | MIDDLE<br>Stuart  |                        |  | LAST   |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4 17 07   |                                    | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>74 YRS.   |                        | 7. IF UNDER 1 YR.<br>MONTHS DAYS                         |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>1 26 19 82  |                        | 2d. HOUR<br>12:20 a.m.                                   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Good Samaritan Hospital |   |   |                                    | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                   |                        | 12b. KIND OF BUSINESS OR INDUSTRY                        |  |  |
| 13a. STATE<br>Md.  |  | 13b. COUNTY<br>-----  |   | 13c. CITY OR TOWN<br>Balto.   |                                    | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                        | 13e. STREET ADDRESS<br>5920 Marluth Ave., 21206          |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST               |   |                                    |   |                        |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>Unkn.   |  |   | 16b. SOCIAL SECURITY NO.<br>243-16-9052A                    |   |                                    | 17. INFORMANT ADDRESS   |                        |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease<br>4292<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost:<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF                       |  |   |   |   |                                    |   |                        |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |   |   |   |                                    |   |                        |  |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |   |                                    |   |                        |  | 20. AUTOPSY?<br>HEAD ONLY<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)                   |                        |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |   |                                    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                        |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |   |   |                                    |   |                        |  |  |  |
| ACTUAL SIGNATURE<br><i>Thomas D. Smith</i>   |  |   | TITLE (SPECIFY)<br>M.D. Deputy Chief                        |   |                                    |   | DATE SIGNED<br>1/26/82 |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Thomas D. Smith, M.D.  |  |   | ADDRESS<br>111 Penn St. Balto., MD.                         |   |                                    |   |                        |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Removal  |  |   | 23b. DATE<br>1/27/82  |   | 23c. NAME OF CEMETERY OR CREMATORY |   |                        | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE               |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Anatomy Board  |  |   | ADDRESS<br>Balto., Md.                                      |   |                                    | 25a. DATE REC'D. BY REGISTRAR<br>FEB 1 1982   |                        | 25b. REGISTRAR'S SIGNATURE<br><i>Frances Jan Weather</i> |  |  |

REC'D - 10-10-50

*Edward R. ...*

RECEIVED

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

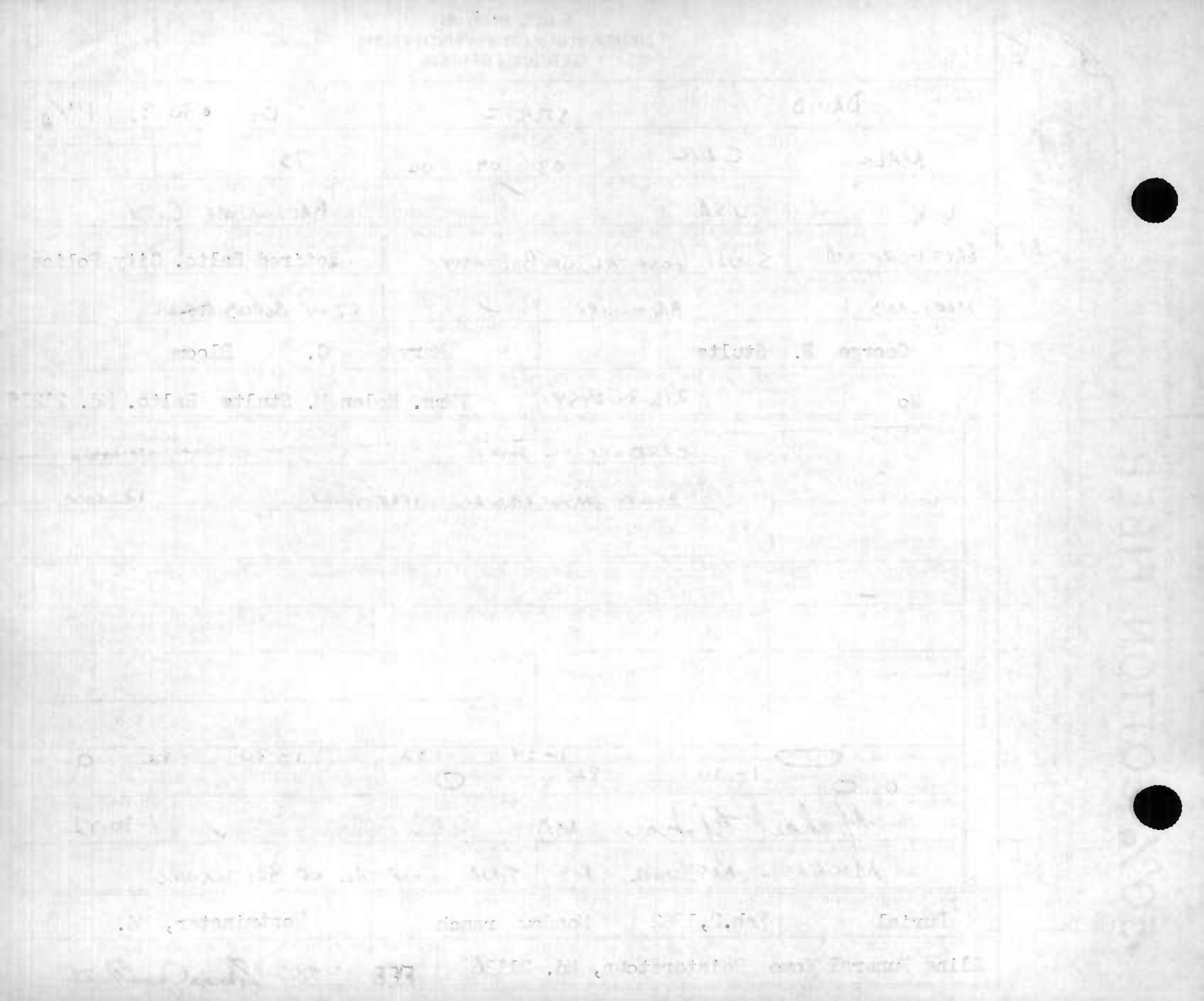
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |  |  |  |   |  |
|--|--|---|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>DAVID</b>  |  | FIRST<br><b>STULTZ</b>  |  | MIDDLE<br><b>STULTZ</b>   |  | LAST<br><b>STULTZ</b>   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>01 030 82</b>  |  | 2b. HOUR<br><b>11<sup>5</sup>/A.M.</b>  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>CAUC</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>03 09 06</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>75</b>  |  | IF UNDER 24 HRS.<br>HOURS MIN.<br><b>11<sup>5</sup></b>                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>UNK</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE MD</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSPITAL OF BALTIMORE</b> |  |   |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired Balto.</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>City Police</b>                           |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   |  |   |  |  |  |   |  |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>5704 BLAND AVENUE</b>  |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George B. Stultz</b>  |  |   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary C. Bloom</b>                           |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>216-34-0458</b>  |  | 17. INFORMANT ADDRESS<br><b>Mrs. Helen M. Stultz Balto. Md. 21215</b>   |  |   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOGENIC SHOCK</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ACUTE MYOCARDIAL INFARCTION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>4/100</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 hours</b><br><b>12 hours</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1-29</b> , 19 <b>82</b> , to <b>1-30</b> , 19 <b>82</b> , that (we) (we) last saw the deceased alive on <b>1-30</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.                              |  |   |  |   |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Michael McIvor MD</b>   |  |   |  |   |  | DEGREE<br><b>MD</b>   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1-30-82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MICHAEL MCIVOR MD</b>  |  |   |  |   |  | 22e. ADDRESS<br><b>SINAI HOSPITAL OF BALTIMORE</b>  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>Feb. 2, 1982</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Meadow Branch</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Westminster, Md.</b>                           |  |  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Eline Funeral Home Reisterstown, Md. 21136</b>  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 1 1982</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>James J. Neather</b>  |  |   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |   |   |  |   |  |  |
|--|--|--|---|---|---|--|---|--|--|
| FOR STATE REGISTRAR  |  |  |   |   | REG. NO.  |  |   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>WILLIAM S. SUDBRINK</b>  |  |  |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>1/ 30/82</b>                                   |  |   | 2b. HOUR<br>M  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>8 26 1898</b>   |   | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>83</b> YRS   |   | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 74 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2607 Wilkens Avenue</b> |   |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Plumber</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Self Emp.</b>  |  |
| 13a. STATE<br><b>Maryland</b>  |  |  | 13b. COUNTY   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Frank Sudbrink</b>   |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Frances Cruchley</b> |   |   | 13e. STREET ADDRESS<br><b>2607 Wilkens Avenue 21223</b>  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>218-01-3125</b>                        |   | 17. INFORMANT ADDRESS<br><b>Veronica C. Weinkan 7915 Mansion Crossing House 21122</b> |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <b>SQUAMOUS CARCINOMA, METASTATIC, UNKNOWN</b><br>1991<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |  |   |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |  |   |   |   |  |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                      |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>        |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)        |  |   |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>JAN 19 81</b> , to <b>JUNE 11 19 81</b> , that (we) last saw the deceased alive on <b>JUNE 11 19 81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.                                   |  |  |   |   |   |  |   |  |  |
| 22b. SIGNATURE<br><b>N.T. Goodchild</b>  |  |  | DEGREE<br><b>M.B. B.S.</b>  |   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>FEB. 3<sup>rd</sup> 1982</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Seymour Weiner, MD</b>   |  |  | 22e. ADDRESS<br><b>1900 E. Northern Pkwy</b>                          |   |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>2/3/82</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b>                     |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>                            |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Hubbard Funeral Home, Inc.</b>   |  |  | ADDRESS<br><b>4107 Wilkens Ave.</b>                                   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 3 1982</b>                                    |  | 25b. REGISTRAR'S SIGNATURE<br><i>James J. Smith</i>   |  |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 1 5 4 0

FOR  
1- STATE  
REGISTRAR

REG. NO.

|  |   |   |  |   |   |
|--|---|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Edna Summerville</b>          |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>1/13/82</b>                                   |   | 2b. HOUR<br><b>7:25</b> M   |
| 3. SEX<br><b>FEMALE</b>  | 4. RACE<br><b>B</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>9 14 92</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>89</b> YRS.                 | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD. |   |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>                           | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>LUTHERAN HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Cook-Ret.</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. STATE<br><b>Md.</b>   |   |   | 13b. COUNTY  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                             | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Easton Richardson</b>   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ester Richardson</b>             |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) |   | 16b. SOCIAL SECURITY NO.<br><b>220-30-3937</b>  |  | 17. INFORMANT ADDRESS   |   |

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**Cardiac arrest**

4140  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **Atherosclerotic Heart disease**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

## PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

**Abdominal aorta aneurysm**

|  |  |  |  |
|--|--|--|--|
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/13</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |
| 22b. SIGNATURE<br><b>Moges Gebremariam MD</b>  |  | DEGREE<br><b>MD</b>  | 22c. DATE SIGNED<br><b>1/13/82</b>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Moges Gebremariam</b>  |  | 22e. ADDRESS   |  |

|  |                             |  |   |
|--|-----------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>                     | 23b. DATE<br><b>1/18/82</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arturos Memorial Park</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Citrus Md.</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>CHAS. H. BOWELL FH 319 N. Schroeder St.</b> |                             | 25a. REG. NO. OF FUNERAL HOME<br><b>JAN 20 1982</b>                |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1/12/25

24. 11. 1919

10/10/1919

When a child is born, the mother's body is in a state of readiness to receive the child. The mother's body is in a state of readiness to receive the child. The mother's body is in a state of readiness to receive the child.

Abdominal and thoracic

1/10 1/5 1/2 1/3 1/4 1/5 1/6 1/7 1/8 1/9 1/10 1/11 1/12 1/13 1/14 1/15 1/16 1/17 1/18 1/19 1/20 1/21 1/22 1/23 1/24 1/25 1/26 1/27 1/28 1/29 1/30 1/31 1/32 1/33 1/34 1/35 1/36 1/37 1/38 1/39 1/40 1/41 1/42 1/43 1/44 1/45 1/46 1/47 1/48 1/49 1/50 1/51 1/52 1/53 1/54 1/55 1/56 1/57 1/58 1/59 1/60 1/61 1/62 1/63 1/64 1/65 1/66 1/67 1/68 1/69 1/70 1/71 1/72 1/73 1/74 1/75 1/76 1/77 1/78 1/79 1/80 1/81 1/82 1/83 1/84 1/85 1/86 1/87 1/88 1/89 1/90 1/91 1/92 1/93 1/94 1/95 1/96 1/97 1/98 1/99 1/100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed in the office after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| Item #15 Film G563 1/27/82 rc   |  |  |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 8 2 0 1 5 4 1  |  |   |  |
|---|--|--|--|---|--|---|--|--|--|---|--|
| FOR STATE REGISTRAR   |  |  |  | CERTIFICATE OF DEATH  |  |   |  | REG. NO.   |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>William Page Sutton</i>  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>1 13 82</i>   |  |   |  | 2b. HOUR<br><i>10:55 AM</i>  |  |   |  |
| 3. SEX<br><i>Male</i>   |  | 4. RACE<br><i>White</i>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>May 18 1893</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>88 88</i> YRS   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS<br>HOURS MIN.                         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>West Virginia</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.                               |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>City Hospitals</i> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Cropper</i>              |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Tanning Co.</i>  |  |   |  |
| 13a. STATE<br><i>Maryland</i>   |  | 13b. COUNTY<br><i>Baltimore</i>  |  | 13c. CITY OR TOWN<br><i>Timonium</i>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><i>2308 Eastridge</i>   |  | 21093   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>William Robert Sutton</i>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Martha Mary Mage Lane Cassel</i>  |  |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>Yes</i>  |  | (IF YES, GIVE WAR OR DATES)<br><i>WWI</i>  |  | 16b. SOCIAL SECURITY NO.<br><i>235 05 3334</i>  |  | 17. INFORMANT<br>ADDRESS<br><i>William Sutton, Son Same</i>                                     |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>cardiovascular collapse</i><br><i>0389</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <i>sepsis</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>_____ |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |  |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1/12</i> , 19 <i>82</i> , to <i>1/13</i> , 19 <i>82</i> , that (I) (we) last saw the deceased alive on <i>1/12</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                    |  |  |  |   |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><i>W. D. Stoll</i>  |  |  |  | DEGREE  |  |   |  | 22c. DATE SIGNED<br><i>1/13/82</i>   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>W. D. Stoll</i>   |  |  |  | 22e. ADDRESS<br><i>Balt City Hospital</i>   |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><i>Burial</i>  |  | 23b. DATE<br><i>1-17-82</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Bethel U.M. Cemetery</i>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Durbin, West Virginia</i>                      |  |  |  |   |  |
| 24. FUNERAL DIRECTOR<br><i>Bruzdzinski Funeral Home PA 1407 Old Eastern Ave.</i>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><i>JAN 18 1982</i>   |  |   |  | 25b. REGISTRAR<br><i>Charles S. ...</i>  |  |   |  |

WILLIAM WILSON

1918 JAN 18 10 30 AM

RECEIVED

1918 JAN 18 10 30 AM

1918 JAN 18 10 30 AM

1918 JAN 18 10 30 AM

1918 JAN 18 10 30 AM

1918 JAN 18 10 30 AM  
JAN 18 1918  
JAN 18 1918



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the registrar after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |  |  |
|---|--|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO. 8 2 0 1 5 4 2   |  |   |  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>OLIVE M. SWAM</b>  |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH <b>1</b> DAY <b>21</b> YEAR <b>82</b>                                |  | 2b. HOUR<br><b>M</b>   |  |
| 3 SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>9</b> DAY <b>11</b> YEAR <b>01</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pa.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. City</b> MD.                                  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>301 McMechen St.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Nurse</b>                |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Hospital</b>   |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Balto.</b>   |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>301 McMechen St.</b>   |  |
| 14. FATHER'S NAME<br>FIRST <b>Charles</b> MIDDLE <b></b> LAST <b>Swam</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Augusta</b> MIDDLE <b></b> LAST <b>Hetrick</b>   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>220-22-2246</b>   |  | 17. INFORMANT<br>ADDRESS <b>2930 E. Balto. St. Balto., Md.</b>  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma</b><br><b>1539</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Carcinoma of the Colon</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> |  |  |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Carcinoma of the Breast</b>  |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>7/1/81</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Cancer Left Colon</b>   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 23, 1982</b> , 19 <b>82</b> , to <b>Jan 21, 1982</b> , that (I) (we) lost saw the deceased alive on <b>Nov 11</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.                                 |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Alan C. Woods Jr. M.D.</b>   |  |  |  | DEGREE <b>(Surgeon)</b>   |  |   |  | 22c. DATE SIGNED<br><b>Jan 25, 82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Alan C. Woods Jr. M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>550 N. Broadway Baltimore 21205 Md.</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Removal</b>  |  | 23b. DATE<br><b>1/21/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Anatomy Board</b> ADDRESS <b>Balto., Md.</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 1 1982</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>James D. [Signature]</b>                                       |  |  |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 2 0 1 5 4 3  |  |   |  |
|---|--|---|--|--|--|---|--|
| FOR<br>1. STATE<br>REGISTRAR  |  |   |  | REG. NO.   |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>STANLEY A SYBOR</b>  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>JAN 19 1982</b> 2b. HOUR <b>12 15 P.M.</b>  |  |   |  |
| 3. SEX<br><b>M</b>  |  | 4. RACE<br><b>W</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>APR 7 1925</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>56</b> YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                        |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE</b> City MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST AGNES HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>ENGINEER</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>IBM</b>   |  |
| 13a. STATE<br><b>MD</b>   |  | 13b. CITY OR TOWN<br><b>BALTO WESTVIEW</b>  |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13d. STREET ADDRESS<br><b>6001 KEITHMONT CT.</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ANTHONY SZCZYBOR</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>STEPHANIE KOROS</b>   |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> OR UNKNOWN <input type="checkbox"/> (IF YES, GIVE WAR OR DATES) |  |   |  |
| 17. SOCIAL SECURITY NO.<br><b>219-16-2712</b>   |  | 18. INFORMANT<br><b>LOIS SYBOR</b>  |  | 19. ADDRESS<br><b>6001 KEITHMONT CT.</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PULMONARY EDEMA</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ATRIAL FIBRILLATION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 1/2 HRS.</b><br><b>1 1/2 HRS.</b><br><b>2 YEARS.</b> |  |   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>NO</b>  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>JAN 19</b> , 19 <b>82</b> , to <b>JAN 19</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>JAN 19</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>James E. Taylor</b>  |  | DEGREE<br><b>M.D.</b>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  | 22c. DATE SIGNED<br><b>JAN 19, 1982</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JAMES E. TAYLOR</b>   |  | 22e. ADDRESS<br><b>ST. AGNES HOSPITAL</b>   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>SPECIES <b>BURIAL</b>  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>WOODLAWN</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO IND MD</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>WEBER FUNERAL HOME EDMONDSON AVE</b>   |  | ADDRESS<br><b>5311</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 21 1982</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Frances Jan. Nathan</b>  |  |

